Your King County Benefits

This collection of booklets describes coverage available to you and your eligible family members under the King County regular employee and part-time Local 587 benefit plans. It also explains how King County administers these plans and your rights and responsibilities under them.

Between printings, benefit information is updated through new hire guides, open enrollment materials and the county website (www.metrokc.gov/finance/benefits). Please refer to these other sources for details on plan changes, coverage options and costs.

This collection is divided into the separate booklets listed below. Each booklet has a table of contents following the title page (except for the Glossary and Resource Directory) to help you find specific items.

If you're unsure about the meaning of terms used in these booklets, refer to the Glossary. If you don't find the information you need here, in your new hire guide, open enrollment materials or on the Web, please contact **Benefits and Retirement Operations** at 206-684-1556 or the plans listed in the Resource Directory.

Although these benefit descriptions include certain key features and brief summaries of King County regular employee and part-time Local 587 benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

Booklet 1

Important Facts

Although these benefit descriptions include certain key features and brief summaries of King County regular employee and part-time Local 587 benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

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How to Use This Booklet

This booklet explains how your benefit plans are administered and describes what to do when your family or work situation changes. It also includes information regarding your rights and responsibilities, plus required legal notices. To get a more complete understanding of each benefit, review this booklet along with the specific plan booklet. Together they will give you the details you need to use your plans effectively. If you have questions that are not answered here, you'll find phone numbers and websites for further information in the Resource Directory.

Remember, your best and most current source of information is King County's website – things change quickly and printed materials, such as this booklet, can't keep pace as well as the Web.

This collection of booklets contains general, not exhaustive, information about your plans. Additional details concerning the terms and conditions of coverage for the life, accidental death and dismemberment and long term disability plans are contained in policies and certificates filed with the State of Washington. Copies of the certificates are available from Benefits and Retirement Operations. Additional details concerning the terms and conditions of coverage for all other plans are available from Benefits and Retirement Operations (see Resource Directory booklet).

Benefit Eligibility

► Benefit Eligibility If You're a Regular Employee

If you're in a part-time regular (except part-time Local 587), full-time regular, provisional or term-limited temporary position (your hiring authority can tell you if your position is benefit-eligible), you're eligible:

- For county-paid medical, dental and vision coverage for you and the eligible family members you enroll
- For county-paid basic life, basic accidental death and dismemberment (AD&D) and basic long term disability (LTD) insurance for yourself
- To purchase enhanced life and enhanced AD&D for yourself and eligible family members, plus enhanced LTD for yourself.

If you and your spouse/domestic partner are both county employees, you may not be covered as both an employee and a dependent at the same time under enhanced life and enhanced AD&D, and only one of you may cover your children for enhanced life and enhanced AD&D.

You're also eligible to participate in other county benefit plans:

- You may set aside pretax dollars from your paycheck in a Health Care Flexible Spending Account (FSA) to pay for certain expenses not covered by your medical, dental and vision plans (see Flexible Spending Accounts booklet)
- You may set aside pretax dollars from your paycheck in a Dependent Care FSA to pay for eligible dependent care expenses for your child, disabled spouse or dependent parent (see Flexible Spending Accounts booklet)
- You receive a free Flexpass/employee ID and access to Making Life Easier Program services (free and confidential counseling, home mortgage assistance, child and elder care referral and mildly sick child care)
- You may participate in the King County Employees Deferred Compensation Plan and other programs as described in the Other Benefits guide provided at New Employee Orientation.

You're not eligible for these benefits if you work less than half time or are a temporary or seasonal employee, or if you work in a capacity that, at the discretion of Human Resources, is considered contract labor or independent contracting. If you're not treated as a common law employee by King County for income tax withholding (regardless of any later determination of legal employment status), you're not benefit eligible.

► Benefit Eligibility and Cost If You're a Part-Time Local 587 Employee

If you're a part-time transit operator or an assigned or on-call employee represented by Local 587, you're eligible for one of three benefit plans – Plan 1, Plan 2 or Plan 3.

You're also eligible to participate in other county benefit plans:

- You may set aside pretax dollars from your paycheck in a Health Care Flexible Spending Account (FSA) to pay for certain expenses not covered by your medical, dental and vision plans (see Flexible Spending Accounts booklet)
- You may set aside pretax dollars from your paycheck in a Dependent Care FSA to pay for eligible dependent care expenses for your child, disabled spouse or dependent parent (see Flexible Spending Accounts booklet)
- You receive a free Flexpass/employee ID and access to Making Life Easier Program services (free and confidential counseling, home mortgage assistance, child and elder care referral and mildly sick child care)
- You may participate in the King County Employees Deferred Compensation Plan and other programs as described in the Other Benefits guide provided after your qualification date.

Plan 1. You become eligible for coverage the first of the month following your qualification or hire date, whichever is later. Your hire date is determined by your department. If your qualification or hire date is the first of the month, you become eligible the same day.

Under Plan 1, you may purchase health coverage (medical, dental, vision) for yourself and eligible family members (you may cover them under all or any plan you elect for yourself), plus basic life insurance ($20,000) for yourself. Certain restrictions apply:

- You must elect medical coverage to elect dental coverage (if you, as the employee, elect medical and dental coverage for yourself, you may cover a family member for dental only)
- If you don't elect basic life insurance when you're first eligible, or elect and drop it later, you may not add it again.

You pay for Plan 1 benefits through payroll deduction. The monthly cost of benefits is divided in half and deducted from your two regular paychecks each month. (When there are three paychecks in a month, no deductions are taken from the last one.)

You may have the deductions taken before or after federal income and Social Security taxes are withheld. If you have deductions taken after-tax, you do not reduce your taxes, but may drop coverage for yourself or a family member anytime. You may change how your payment deductions are taken (before-tax or after-tax) only during open enrollment.

Before-tax deductions do reduce your taxes. However, IRS restrictions apply:

- Any portion you pay to provide coverage to a domestic partner or domestic partner's children is an after-tax deduction
- You may not drop any coverage until the next open enrollment unless it's due to a qualifying change in status:
  - Death of a family member
  - Divorce, legal separation or dissolution of a domestic partnership
  - Significant change in your spouse's or domestic partner's coverage due to his/her employment
- You must re-enroll for before-tax deductions every year during open enrollment or you default to the after-tax arrangement.

Plan 2. Eligibility for Plan 2 is determined by an agreement between King County Metro Transit and Amalgamated Transit Union Local 587 based on working sufficient hours. Direct any questions regarding eligibility for Plan 2 to your base chief.

You become eligible when you have 338 paid hours in either of two four-month periods:

- November 1-February 28/29 (Plan 2 benefits begin May 1)
- March 1-June 30 (Plan 2 benefits begin September 1).

Plan 2 benefits extend through the end of the calendar year. They continue through the end of the following calendar year if you:

- Have an average of 39 hours or more per pay period in the 26 consecutive pay periods that end with the pay period including July 31 (you must have been employed as a part-time Local 587 employee for at least the most recent six complete pay periods to qualify), or

- Pick assignments averaging four hours or more for the February, June and September shake-ups (you must have picked assignments for all three shake-ups to qualify).

Under Plan 2, you receive county-paid medical, dental and vision coverage for you and the eligible family members you enroll, plus the following basic coverage for yourself: life, accidental death and dismemberment (AD&D), and long term disability (LTD) insurance. When you first enroll under Plan 2, you may also purchase enhanced life and AD&D for yourself and eligible family members, plus enhanced LTD for yourself.

If you and your spouse/domestic partner are both county employees, you may not be covered as both an employee and a dependent at the same time under enhanced life and enhanced AD&D, and only one of you may cover your children for enhanced life and enhanced AD&D.

Plan 3. When you lose eligibility for Plan 2, you become eligible for Plan 3.

Under Plan 3, you continue to receive the same county-paid basic life, AD&D and LTD coverage you had under Plan 2 and may continue enhanced life, AD&D and LTD coverage. If you choose to continue medical, dental and vision coverage for yourself and eligible family members, you pay for the coverage. The rates are the same as Plan 1 coverage.

► Benefit Eligibility for Family Members

Eligible family members include:

- Your spouse/domestic partner (copy of marriage certificate or an Affidavit of Marriage/Domestic Partnership must be filed with Benefits and Retirement Operations)
- Unmarried children of you or your spouse/domestic partner if they are under age 23 (life insurance doesn't cover children under 14 days old) and chiefly dependent on you for support and maintenance (generally, that means you may claim them on your federal tax return). They may be your:
  - Natural children
  - Adopted children (or children legally placed with you for adoption or for whom you assume total or partial legal obligation for support in anticipation of adoption)
  - Stepchildren
  - Legally designated wards (legally placed foster children, children placed with you as legal guardian or children named in a Qualified Medical Child Support Order as defined under federal law and authorized by the plans; see below)
- A child 23 or older if the child:
  - Was covered under your plans before age 23, and
  - Is incapacitated due to developmental or physical disability and chiefly dependent on you for support.

For a disabled child, you must submit a Continue Coverage for Disabled Adult Child form to Benefits and Retirement Operations within 30 days of the child's 23rd birthday, and provide proof of the child's continued disability periodically thereafter.

Parents and other relatives who are not members of your immediate family are not eligible for coverage.

Domestic Partners. There is no cost for family member health coverage if you qualify for regular or part-time Local 587 Plan 2 benefits. However, when you cover a domestic partner and domestic partner's children for health benefits (medical, dental, vision), the IRS taxes you on the value of the coverage. This value is added to the salary shown on your paycheck (and W-2 at year-end); federal income and Social Security (FICA) taxes are withheld on the higher salary amount, then the value is subtracted from your salary.

Qualified Medical Child Support Order (QMCSO). In accordance with applicable law, the plans provide medical, dental and vision coverage to certain children of yours (called "alternate recipients") if directed by certain court or administrative orders. These include a decree, judgment or order from a state court (including approval of a settlement agreement) or an administrative order that requires these plans to include a child in your coverage and make any applicable payroll deductions.

A QMCSO is generally considered qualified and enforceable if it specifies:

- Employee name and last known address
- Each alternate recipient's name and address
- Coverage the alternate recipient will receive
- The coverage effective date
- How long the child is entitled to coverage
- Each plan subject to the order.

Benefits and Retirement Operations promptly notifies you and the alternate recipient when a QMCSO is received and explains what procedures will be used to determine if the order is qualified. Once the determination is made, Benefits and Retirement Operations notifies you and the alternate recipient by mail.

Enrolling in the Plans

► Enrolling If You're a Regular Employee

You must submit the benefit enrollment forms included in your Regular Employee New Hire Guide within 30 days of your hire date, or your eligible family members won't be covered and you'll be assigned the following default coverage:

- KingCare Basic Medical
- Dental
- Vision
- Basic life insurance
- Basic AD&D insurance
- Basic LTD insurance.

You have several medical plan choices, and may also opt out of medical coverage and receive an additional $65 in monthly pay taxed as ordinary income. To opt out of medical coverage, you must have coverage through another employer's health care plan and submit a copy of the other medical plan ID card with your enrollment form. (When you opt out of medical, your other benefits are not affected.)

You may opt out only when you're first eligible for benefits or at open enrollment. Even if you become covered under another medical plan, you must wait until the next open enrollment to opt out of county medical coverage.

If you opt out of medical, you may opt back in before open enrollment if you lose your other medical coverage and return a completed Opt Back In form to Benefits and Retirement Operations within 30 days of losing that coverage (coverage becomes effective the first of the month after your other coverage ends). Otherwise, you must wait until the next open enrollment (coverage becomes effective January 1).

If you decide to participate in a Flexible Spending Account, you must submit an FSA Enrollment form available from Benefits and Retirement Operations (see Resource Directory booklet) within 30 days of when your other benefits begin. Otherwise, you must wait for a qualifying change in status or the next open enrollment. You must re-enroll each year at open enrollment to continue participating in an FSA (see Flexible Spending Accounts booklet).

If default coverage is assigned:

- **Health Coverage and AD&D.** You must wait until the next open enrollment to change medical plans, elect enhanced AD&D and add eligible family members for coverage
- **Life.** You may not add enhanced life at open enrollment, but you may add it during the year if certain qualifying events occur (see "Changes You May Make When a Qualifying Event Occurs")
- **LTD.** You receive basic LTD but lose the opportunity to add enhanced LTD later.

► Enrolling If You're a Part-Time Local 587 Employee

You receive enrollment materials for each plan as you become eligible.

If you decide to participate in a Flexible Spending Account, you must submit the FSA Enrollment form available from Benefits and Retirement Operations within 30 days of when you become eligible for Plan 1 or Plan 2 benefits. (You are not eligible to enroll in an FSA when you become eligible for Plan 3). Otherwise, you must wait for a qualifying change in status or the next open enrollment. You must re-enroll each year at open enrollment to continue participating in an FSA (see Flexible Spending Accounts booklet).

Plan 1. You must submit your enrollment form within 30 days of your eligibility date (sooner if possible). Otherwise, you must wait until the next open enrollment to enroll in Plan 1. (If you don't elect basic life insurance when you are first eligible, you may not add it again.)

Plan 2. You must submit your enrollment form by the deadline indicated in your Plan 2 materials (the materials are mailed to you approximately one month before your Plan 2 eligibility begins). Otherwise, only eligible family members you've previously enrolled in a county medical plan will be covered and you'll receive the following default coverage:

- KingCare Basic Medical (if you've never been enrolled in a county medical plan) or the last county medical plan you were in (if it's still available to you)
- Dental
- Vision
- Basic life insurance
- Basic AD&D insurance
- Basic LTD insurance.

When you become eligible for Plan 2 you may opt out of medical coverage and receive an additional $65 in monthly pay taxed as ordinary income. To opt out of medical coverage, you must have coverage through another employer's health care plan and submit a copy of the other medical plan ID card with your enrollment form. (When you opt out of medical, your other Plan 2 benefits are not affected.)

You may opt out only when you first enroll for Plan 2 benefits or at open enrollment. Even if you become covered under another medical plan, you must wait until the next open enrollment to opt out of county medical coverage.

If you opt out of medical, you may opt back in before open enrollment if you lose your other medical coverage and return a completed Opt Back In form to Benefits and Retirement Operations within 30 days of losing that coverage (coverage becomes effective the first of the month after your other coverage ends). Otherwise, you must wait until the next open enrollment (coverage becomes effective January 1).

If you decide to participate in a Flexible Spending Account, you must submit an FSA Enrollment form available from Benefits and Retirement Operations (see Resource Directory booklet) within 30 days of when your Plan 2 benefits begin. Otherwise, you must wait for a qualifying change in status or the next open enrollment. You must re-enroll each year at open enrollment to continue participating in an FSA (see Flexible Spending Accounts booklet).

If default coverage is assigned:

- **Health Coverage and AD&D.** You must wait until the next open enrollment to change medical plans, elect enhanced AD&D and add eligible family members for coverage
- **Life.** You may not add enhanced life at open enrollment, but you may add it during the year if certain qualifying events occur (see "Changes You May Make When a Qualifying Event Occurs")
- **LTD.** You receive basic LTD but lose the opportunity to add enhanced LTD later.

Plan 3. You must submit your enrollment form by the deadline indicated in your Plan 3 materials (the materials are mailed to you approximately one month before your Plan 3 eligibility begins). Otherwise, all previous Plan 2

coverage except basic life, basic AD&D and basic LTD for you will end the day before your Plan 3 eligibility begins, and you:

- Must wait until the next open enrollment to add health (medical, dental, vision), elect enhanced AD&D and add eligible family members for coverage (see "Changes You May Make When a Qualifying Event Occurs")
- May not add enhanced life again until certain qualifying events occur (see "Changes You May Make When a Qualifying Event Occurs")
- May not add enhanced LTD.

When Coverage Begins

► When Coverage Begins If You're a Regular Employee

Coverage begins the first of the month following your hire date, as determined by your department (unless modified by your collective bargaining agreement). If your hire date is the first of the month, your coverage begins the same day.

When you change coverage during open enrollment, your new coverage begins January 1 of the following year and stays in effect for the entire calendar year, as long as you remain eligible.

When you're first eligible, the start of some coverage may be delayed:

- **Medical.** If you're hospitalized on the day coverage would start, coverage begins after discharge.
- **Life.** If you're not actively at work on the day coverage would start because of illness or injury, coverage begins on your first full day back at work.
- **AD&D.** If you're not regularly performing the duties of your occupation on the date coverage would start, coverage begins on the first day of the month following your return to those duties.
- **LTD.** If you're not actively at work on the day coverage would start, coverage begins on the day you return to work; active work includes holidays, vacation days and approved paid leaves (other than sick leave), as long as you worked the day preceding the scheduled work day.

► When Coverage Begins If You're a Part-Time Local 587 Employee

Plan 1. If you enroll, coverage begins the first of the month following your qualification or hire date, whichever is later. Your hire date is determined by your department. If your hire date is the first of the month, your coverage begins the same day.

When you first enroll for Plan 1, the start of some coverage may be delayed:

- **Medical.** If you're hospitalized on the day coverage would start, coverage begins after discharge.
- **Life.** If you're not actively at work on the day coverage would start because of illness or injury, coverage begins on your first full day back at work.

When you change coverage during open enrollment, your new coverage begins January 1 of the following year and stays in effect for the entire calendar year (as long as you remain eligible), unless you qualify for Plan 2 effective May 1 or September 1 (see "Plan 2" information).

Plan 2. Coverage begins January 1, May 1 or September 1, depending on your eligibility date.

When you're first eligible for Plan 2, the start of some coverage may be delayed:

- **Medical.** If you're hospitalized on the day coverage would start, coverage begins after discharge.
- **Life.** If you're not actively at work on the day coverage would start because of illness or injury, coverage begins on your first full day back at work.
- **AD&D.** If you're not regularly performing the duties of your occupation on the date coverage would start, coverage begins on the first day of the month following your return to those duties.

- **LTD.** If you're not actively at work on the day coverage would start, coverage begins on the day you return to work; active work includes holidays, vacation days and approved paid leaves (other than sick leave), as long as you worked the day preceding the scheduled work day.

When you change coverage during open enrollment, your new coverage begins January 1 of the following year and stays in effect for the entire calendar year, as long as you remain eligible.

Plan 3. Coverage begins January 1 and stays in effect for the entire calendar year (as long as you remain eligible), unless you re-qualify for Plan 2 effective May or September 1 (see "Plan 2" information).

► When Coverage Begins for Eligible Family Members

Coverage for the eligible family members you list on your enrollment form begins when your coverage begins, with the exceptions listed below. If you don't enroll eligible family members when you enroll, you must wait until the next open enrollment or a qualifying change in status to add them for coverage (see "Changes You May Make When a Qualifying Event Occurs" in this booklet).

For eligible family members added due to a qualifying change in status, health coverage (medical, dental and vision) for your:
- Newborn or newly adopted child is retroactive to the date of birth or placement
- Child (other than a newborn or adopted) begins the first of the month following the event that qualified him/her to be added; if the event occurs on the first of the month, coverage begins the same day
- New spouse/domestic partner begins the first of the month following the date you marry/establish your domestic partnership as indicated on the copy of your marriage certificate or Affidavit of Marriage/Domestic Partnership; if you marry or establish your domestic partnership on the first of the month, coverage begins the same day.

Coverage under all medical plans is provided for newborns under the mother's benefits for the first three weeks of life. To continue the newborn's coverage after that, the newborn must be eligible and enrolled within 60 days of birth.

Generally, if you elect enhanced life and AD&D for your eligible family members, their coverage begins the first of the calendar month premium deductions are taken from your paycheck. In some cases, however, the start of coverage may be delayed:
- **Life.** Children younger than 14 days are not eligible for life insurance, so coverage does not begin until the 14th day.
- **AD&D.** If they're confined in a hospital or other facility at the time coverage would typically begin, coverage begins on the first day of the month following discharge (except for newborns).

Making Changes: General Information

The next four sections describe how to make changes to your benefit coverage between first enrolling and leaving county employment. Your change may require supporting documentation and one or more of these forms:
- Add New Family Member
- Affidavit of Marriage/Domestic Partnership
- Beneficiary Designation
- Continue Coverage for Disabled Adult Child
- Delete Family Member
- Enhanced Life/AD&D Change
- Flexible Spending Account Enrollment
- Opt Back In
- Personal Information Update.

All forms are available at www.metrokc.gov/finance/benefits or from Benefits and Retirement Operations (see the Resource Directory booklet).

You Must Drop Ineligible Family Members

You must drop family members from coverage when they are no longer eligible (see "Benefit Eligibility for Family Members" in this booklet). To drop ineligible family members, submit a Delete Family Member Form to Benefits and Retirement Operations within 30 days of the date they become ineligible. The date a family member becomes ineligible is reported to the carriers and any expenses incurred after that date are your responsibility.

Benefits and Retirement Operations must receive the form by the fifth of the month to stop payroll deductions for any premiums you pay that month.

When you drop ineligible family members:
- They may continue health coverage under COBRA or individual self-paid insurance (when you divorce and the divorce decree states you must provide health insurance for your ex-spouse, you must drop your ex-spouse from county-paid coverage and continue coverage through COBRA or individual self-paid insurance)
- You may add them back to your coverage if and when they become eligible again.

Changes You May Make Anytime

You May Drop Eligible Family Members from Coverage

You may drop eligible family members from coverage anytime – except for health coverage you pay for through before-tax payroll deduction (part-time Local 587 Plan 1 or 3). If you pay for their health coverage through before-tax payroll deduction, you may drop family members only when a relevant qualifying change in status occurs – for example, you divorce/end a domestic partnership, a family member dies, a child is no longer a dependent, a Qualified Medical Child Support Order ends or a family member becomes eligible for his/her own benefit plan. If you do not have a relevant qualifying change in status, you must wait until the next open enrollment.

To drop a family member, submit a Delete Family Member form. Benefits and Retirement Operations must receive the form by the fifth of the month to stop payroll deductions for any premiums you pay that month for coverage. The date a family member is dropped is reported to the carriers and any expenses incurred after that date are your responsibility.

When you voluntarily drop family members, you may not add them back again:
- For health coverage (medical, dental and vision), until the next open enrollment or a qualifying change in status occurs (see "Changes You May Make When a Qualifying Event Occurs")
- For life insurance, except for certain qualifying events (see "Changing Enhanced Life/AD&D Coverage")
- For AD&D, until the next open enrollment or a qualifying change in status occurs (see "Changing Enhanced Life/AD&D Coverage").

You May Drop or Reduce Self-Paid Coverage

You may drop or reduce any coverage you pay for anytime – except for health coverage you pay for through before-tax payroll deduction (part-time Local 587 Plan 1 or 3). If you pay for health coverage through before-tax payroll deduction , you may drop coverage only when a relevant qualifying change in status occurs – for example, you become eligible for other health coverage. If you do not have a relevant qualifying change in status, you must wait until the next open enrollment.

To drop or reduce coverage, submit a detailed written or email request (no form is available). Benefits and Retirement Operations must receive your request by the fifth of the month to stop or reduce payroll deductions for any premiums you pay that month for coverage. The date coverage is dropped is reported to the carriers and any expenses incurred after that date are your responsibility.

If you:

- Drop health coverage (medical, dental or vision coverage under part-time Local 587 Plan 1 or 3), you may not add it again until the next open enrollment or you subsequently lose the coverage that qualified you to drop your self-paid county coverage (see "You May Request Health Coverage Previously Declined/Opted Out" in the next section)
- Drop basic life (part-time Local 587 Plan 1 only), you may not add it again
- Drop or reduce enhanced life, you may add or increase it again only when certain qualifying events occur (see "Changes You May Make When a Qualifying Event Occurs" in this booklet)
- Drop or reduce enhanced AD&D, you may add or increase it again only during open enrollment
- Drop enhanced LTD, you may not add it again.

Changes You May Make When a Qualifying Event Occurs

► You May Add Eligible Family Members for Health Coverage

Except for birth or placement for adoption, you must submit an Add New Family Member form within 30 days of these qualifying events (sooner if possible) to add an eligible family member for health coverage (medical, dental, vision):

- Placement of a legal ward
- Marriage or establishment of a domestic partnership
- Significant change in your spouse/domestic partner's employer-sponsored coverage.

If you do not submit the form within 30 days, you must wait until the next open enrollment to add the eligible family member for coverage.

Birth or Placement for Adoption. A newborn is automatically covered under the mother's coverage for the first three weeks. You have 60 days to add a newborn or a newly adopted child for health coverage, but because you have only 30 days to make changes to enhanced life/AD&D coverage, it's highly recommended you submit all forms within 30 days of birth or placement for adoption to take advantage of your life/AD&D change options.

If you do not submit the form within 60 days, you must wait until the next open enrollment to add the eligible family member for coverage.

Qualified Medical Child Support Order. When Benefits and Retirement Operations receives a QMCSO, the child is automatically added for coverage according to the terms of the document (you do not need to submit an Add New Family Member form).

► You May Change Enhanced Life/AD&D Coverage

You must submit an Enhanced Life/AD&D Change form within 30 days of a qualifying event to change your enhanced life and AD&D coverage.

Enhanced Life. You may add or increase enhanced life insurance for yourself and add a:

- Spouse/domestic partner for enhanced life when he/she:
  - Becomes your new spouse/domestic partner (if you do not elect enhanced life for your domestic partner when he/she is first eligible, you may not elect the coverage if he/she becomes your spouse; future marriage to the same person is not a qualifying event), or
  - Loses his/her own county or other employer-provided coverage
- Child when he/she:
  - First becomes eligible
  - Loses county or other employer-provided coverage under a spouse/domestic partner's coverage.

If you don't submit the form within 30 days, you may not add the family member for enhanced life again, with one exception: when you add one child during a qualified family status change for enhanced life, the coverage is

automatically extended to all eligible dependent children enrolled under your benefit plans, including children previously not covered or dropped from enhanced life coverage.

Enhanced AD&D. If you have enhanced AD&D coverage for yourself, you may add a:

- Spouse/domestic partner for enhanced AD&D when he/she:
  - Becomes your new spouse/domestic partner (if you do not elect enhanced AD&D for your domestic partner when he/she is first eligible, you may not elect the coverage if he/she becomes your spouse; future marriage to the same person is not a qualifying event), or
  - Loses his/her own county or other employer-provided coverage
- Child when he/she:
  - First becomes eligible
  - Loses county or other employer-provided coverage under a spouse/domestic partner's coverage.

If you don't submit the form within 30 days, you may not add the eligible family member for enhanced AD&D until the next open enrollment, with one exception: when you add one child for enhanced AD&D between open enrollments, the coverage is automatically extended to all eligible dependent children enrolled under your benefit plans, including children previously not covered or dropped from enhanced AD&D coverage.

► You May Request Health Coverage Previously Declined/Opted Out

You must submit an Opt Back In form within 30 days of losing other coverage (sooner if possible) if you or a family member loses health coverage through another employer and wishes to opt back in under county plans. If you don't submit the form within 30 days, you may not opt back in under county plans until the next open enrollment.

If your other coverage is COBRA (and you declined county coverage when you first became eligible for any county plan), COBRA must be exhausted before you can opt in to coverage outside of open enrollment. For other than COBRA coverage, the loss of coverage must be due to divorce, legal separation, death, termination of employment, reduction of hours or termination of employer contributions toward the other coverage.

► You May Request Continuation of Coverage for a Disabled Adult Child

You may continue coverage for a child past age 23 if the child is covered under your plans, is incapacitated due to developmental or physical disability and is chiefly dependent on you for support. To do so, submit a Continue Coverage for Disabled Adult Child form six months before the child turns 23 or no later than 30 days after.

Changes You May Make at Open Enrollment

Open enrollment every October lets you make the following changes in coverage without qualifying changes in status:

- Change medical plans
- Add eligible family members
- Add or increase enhanced AD&D for yourself and eligible family members
- Enroll/reenroll in an FSA (you must reenroll each year to continue participating).

Changes you make at open enrollment become effective January 1 of the next year. However, if you drop family members from coverage who are no longer eligible, they are dropped the date they became ineligible, the date is reported to the carriers and any expenses incurred after that date are your responsibility.

When Coverage Ends

► When Coverage Ends for You

Your benefit coverage ends the:
- Last day of the month you lose eligibility, resign, are terminated, retire, fail to make any required payments for self-paid coverage or die, or
- Day the plan terminates.

Certain restrictions apply to AD&D and LTD coverage if you enter military service (see "If You Leave Employment to Perform Uniformed Service").

► When Coverage Ends for Family Members

Family member benefit coverage ends the:
- Last day of the month they lose eligibility, your coverage ends, you fail to make any required payments for their coverage or they die, or
- Day the plan terminates.

Certain restrictions apply to life and AD&D coverage if a covered family member enters military service (see "If You Leave Employment to Perform Uniformed Service"). Also, AD&D coverage for a spouse/domestic partner automatically ends when the spouse/domestic partner reaches age 80.

Family-Medical Leave

► Family-Medical Leave Eligibility

If you've worked for King County at least a year (need not be 12 consecutive months) and have worked 1,040 hours (if you're scheduled to work 40 hours a week), 910 hours (if you're scheduled to work 35 hours a week) or 510 hours (if you're a part-time Local 587 employee) during the 12 months immediately preceding your leave request, you're eligible to take job-protected leave for certain family and medical reasons. Hours counted toward eligibility must be hours actually worked – vacation and sick leave hours do not count.

Under the federal Family and Medical Leave Act (FMLA), you're eligible for up to 12 weeks of leave in a rolling 12-month period, starting with any paid leave you have available and continuing as unpaid leave when your paid leave runs out. Under King County Family and Medical Leave (KCFML), you're eligible for up to 18 weeks of unpaid leave, including any unpaid leave you took under FMLA. However, if you've taken FMLA leave/KCFML during the 12 months immediately preceding your latest request, your maximum allotment is reduced by that amount.

FMLA applies to all county employees. KCFML applies to all nonrepresented employees and represented employees whose unions have agreed to the terms of KCFML (refer to your union contract). If you have questions about FMLA and KCFML eligibility, talk to your supervisor, department's human resources staff or union representative, or contact Benefits and Retirement Operations (see Resource Directory booklet).

► Reasons for Taking Family-Medical Leave

You may take leave for these reasons:
- A serious health condition that makes you unable to perform your job
- Birth of a child
- Caring for your child after birth, adoption or placement for adoption or foster care
- Caring for your spouse with a serious health condition
- Caring for your or your spouse's son, daughter or parent with a serious health condition.

King County also allows FMLA benefits while caring for a domestic partner or domestic partner's son, daughter or parent with a serious health condition.

A serious health condition is an illness, injury, impairment or physical or mental condition that involves one or more of the following:

- An acute episode that requires more than three consecutive calendar days of incapacity and at least one follow-up treatment by a health care provider
- A chronic ailment continuing over an extended time that requires periodic visits by a health care provider and causes continuous or intermittent episodes of incapacity
- Inpatient care in a hospital, hospice or residential medical care facility
- An ailment requiring multiple interventions or treatment by a health care provider
- Any period of incapacity due to pregnancy or prenatal care.

► Advance Notice and Medical Certification for Family-Medical Leave

You must submit your leave request 30 days in advance when your leave is foreseeable or as soon as possible when your leave is not foreseeable.

You also must provide medical certification to support a leave request because of a serious health condition. And if requested, you'll need to submit second or third opinions (at King County's expense) as well as a fitness for duty report to return to work.

► Use of Sick and Vacation Leave for Family-Medical Leave

You must use all your sick leave for your own serious health condition (unless the condition is due to an on-the-job injury). After sick leave is exhausted, you may use vacation and other paid leave if approved.

To care for a family member, you may use sick leave or, if approved, vacation leave. If you use sick leave, you may reserve up to 80 hours of it for your own future use.

You may use donated sick and donated vacation leave for family-medical leave, but if you do, you must use all your own sick leave before using donated sick leave and all your own vacation leave before using donated vacation leave.

► When Family-Medical Leave Begins

FMLA leave begins the first day you are off the job. KCFML begins the first day you're no longer being paid from your own sick leave, vacation or other paid leave accruals. (In most cases, for an on-the-job injury, you may opt to go to unpaid leave status and begin KCFML immediately; refer to your union contract.)

Leave may be taken on a reduced or intermittent work schedule if approved by your supervisor.

► Continuation of Benefits under Family-Medical Leave

Under FMLA leave or KCFML, county-paid medical, dental and vision benefits continue while you're on leave. If you go on unpaid leave status, you may pay the full premium to continue your life insurance for up to 12 months, AD&D for up to six months and LTD for up to 18 weeks. Benefits and Retirement Operations will contact you regarding continuation of benefits when it receives your approved leave request.

► Job Protection under Family-Medical Leave

Upon return from FMLA leave or KCFML, you are restored to your original or equivalent position with equivalent pay, benefits, seniority and other employment terms. You won't lose any employment benefits that accrued before your leave began. No adverse personnel actions may be taken against you for taking FMLA leave or KCFML.

Your job is protected while on FMLA/KCFML. However, you may lose your job protection if you fail to return to work by the expiration date of your approved family-medical leave. Failure to return by the expiration date may be cause for removal and result in termination of your employment.

King County may not interfere with, restrain or deny the exercise of any right provided under FMLA. The county may not discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA. The US Department of Labor is authorized to investigate and resolve complaints of violations, and an FMLA-eligible employee may bring a civil action against King County for violations.

FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

Leave of Absence without Pay

If you do not qualify for leave under FMLA or KCFML, your benefit coverage for medical, dental and vision:

- Continues uninterrupted if your unpaid leave is less than 31 days
- May be continued under COBRA if your unpaid leave is 31 days or more (county coverage ends the last day of the month you work before the leave begins).

If you are on leave past your FMLA/KCFML period on unpaid status, your benefit coverage may be continued under COBRA.

If You Become Disabled

► Accommodation Policy If You Become Disabled

Under federal (American with Disabilities Act), state and local laws, King County provides reasonable accommodations for you if you are disabled, regardless of how or when you become disabled, or whether the disability is permanent or temporary. Disabilities may be caused by injury, accident or disease, or may have been present since birth.

► What to Do If You Become Disabled

If you become disabled:

- File a workers' compensation claim with Safety & Claims Management if the disability is work related
- Contact the Disability Services Program (Local 587 employees contact Metro Transit Human Resources)
- Apply for family-medical leave (FMLA/KCFML) with your supervisor if your disability keeps you from working
- File a claim for LTD benefits with CIGNA if you have them and you're going to be off work beyond your waiting period (you must provide proof of your disability within 12 months after your disability begins and then annually, or your claim may be denied; you must continue to pay the premium during your waiting period; see the CIGNA Long Term Disability Insurance booklet)
- Contact Benefits and Retirement Operations about continuing your life insurance and Health Care Flexible Spending Account (see appropriate plan booklets)
- Contact the Washington State Department of Retirement Systems to discuss benefit options if your disability keeps you from working
- Contact T. Rowe Price, King County's deferred compensation plan administrator, if you are a participant and your disability has created an unforeseen financial hardship (you may qualify for a hardship withdrawal)
- Apply for Social Security disability income if your disability qualifies.

See the Resource Directory booklet for contact details.

► Continuation of Health Benefits If You Become Disabled

Under Family-Medical Leave. If your disability qualifies you for leave under FMLA, KCFML or both, your health coverage (medical, dental, vision) continues for the length of the leave.

Under Leave of Absence without Pay. If you do not qualify for leave under FMLA or KCFML, or you continue on leave past your FMLA/KCFML period on unpaid status, your health coverage ends. You may be eligible to pay to continue coverage under COBRA (see "COBRA" in this booklet).

If you or covered family members in the KingCare Basic or Preferred medical plans are totally disabled, and your coverage ends for any reason except plan termination, medical coverage for only the disabling condition may be extended for 12 months at no cost to you. The disabled person may choose either this medical extension or COBRA coverage, but electing the extension means they forfeit the right to elect COBRA coverage and convert to an individual policy. Other family members may be able to elect coverage through COBRA.

Medical extension coverage will end on the date coverage terminates for the group you were in when you became disabled or on the date you or your family members experience any of the following:
- Reach any lifetime maximum
- Are no longer disabled
- Become eligible for benefits under another group policy
- Reach the end of the 12-month extension.

If you or covered family members in the Group Health medical plan become disabled, your coverage ends. You may be eligible to continue coverage under a family-medical leave and then under COBRA.

► Continuation of Life Insurance If You Become Disabled

If you notify Benefits and Retirement Operations within 30 days of when you become disabled, your coverage may be continued for up to 12 months or longer. See the Aetna Life Insurance booklet for details.

► Continuation of AD&D Insurance If You Become Disabled

If you're disabled and notify Benefits and Retirement Operations within 30 days of your disability, your basic AD&D continues at no cost to you for up to six months after the disability occurs. If you're not disabled and not terminated from county employment, you may self-pay to continue your enhanced AD&D for up to six months while on an approved leave of absence.

► Continuation of LTD If You Become Disabled

If your leave is due to your own disability and continues beyond the FMLA/KCFML period, you may continue to pay the premiums through the remainder of your LTD benefit waiting period. While you're receiving LTD benefits, you will not be responsible for monthly premiums.

► Job Reassignment and Search Assistance If You Become Disabled

If you cannot be accommodated in your regular job and are separated from your position, employment placement assistance is provided through the Disability Services Program in two phases, lasting up to nine months. The program will help you:
- Be reassigned through a non-competitive hiring process during the first four months
- Find and apply to posted job positions as an internal candidate for an additional five months if reassignment is unsuccessful.

COBRA

► COBRA Eligibility

If you or your qualified family members lose county-paid health coverage due to certain events, each of you has an independent right to self-pay under the Consolidated Omnibus Budget Reconciliation Act (COBRA) for health coverage (medical, dental, vision). This coverage may continue for 18 to 36 months after county-paid coverage ends (the last day of the month the qualifying event occurs). Length of the COBRA continuation coverage period depends on the event:

- Termination of employment if for reasons other than gross misconduct – 18 months
- Layoff – 18 months
- Reduction in work hours/no longer eligible for county-paid benefits – 18 months
- Disability – 29 months if you or family members are determined Social Security disabled at the time of or within 60 days of when COBRA eligibility begins; the COBRA participant must provide a copy of the Social Security disability determination to AAI, King County's COBRA administrator, before the end of the first 18 months of COBRA coverage and within 60 days after being determined disabled under Social Security)
- Death – 36 months for surviving qualified family members
- Divorce/dissolution of domestic partnership – 36 months for qualified family members
- Dependent child ceases to be a dependent (may no longer be claimed as an IRS dependent or reaches age 23) – 36 months for child
- Medicare entitlement – 36 months for qualified family members.

If a second qualifying event occurs during an 18- or 29-month COBRA continuation coverage period, coverage may be continued for eligible family members for up to 36 months from the first qualifying event, but the total COBRA continuation coverage period will not exceed 36 months.

You and your qualified family members may elect coverage even if covered under another employer-sponsored health plan or entitled to Medicare at the time you elect coverage.

If you are participating in a Health Care Flexible Spending Account when you become eligible for COBRA, you may continue participating through the end of the calendar year (see the Flexible Spending Accounts booklet).

► COBRA Enrollment

COBRA-qualifying events (other than divorce, dissolution of a domestic partnership or child reaching age 23) are reported to Benefits and Retirement Operations through your termination notice or payroll report. For family members who lose coverage through you because of divorce, dissolution of a domestic partnership or child reaching age 23, you must notify Benefits and Retirement Operations within 60 days of the last of the month the qualifying event occurs or the date coverage ends, if later. Otherwise, the family member will not be offered the option to elect COBRA continuation coverage (see "Dropping Family Members from Coverage" in this booklet).

When COBRA-qualifying information is received, Benefits and Retirement Operations notifies Associated Administrators Inc. (King County's COBRA benefits administrator), who contacts you/family members regarding benefit plan options.

You have 60 days after coverage ends to make your COBRA elections or, if later, 60 days from the date of the AAI letter notifying you of your options. If you elect COBRA continuation coverage, you must make the initial payment by the 45th day after electing it. Thereafter, all premiums are due the first of the month; coverage automatically ends if payment is not made within 30 days. AAI will give you payment information.

Once you have elected COBRA and paid the premium, COBRA continuation coverage is retroactive. There is no lapse in coverage – self-paid benefits begin when county-paid benefits end, even if retroactive processing and payments are required. Your initial payment must include all applicable back premiums.

► COBRA Options

Your COBRA options will be explained in the enrollment information you receive from AAI. COBRA allows you to self-pay to continue all the health coverage (medical, dental and vision) you have on your last day of employment or one of these options (if you qualify):

- Medical only (as long as medical was included as part of your health coverage on your last day)
- Medical and vision (if you had medical and vision but no dental on your last day)
- Dental and vision (if you had dental and vision but no medical on your last day)
- Vision only (if vision is the only coverage you had on your last day).

You may continue covering the same family members who were covered the last day of your employment or you may drop any of them from coverage anytime. If you drop family members from coverage, they have their own COBRA rights. However, family members added after you elect COBRA coverage do not have separate COBRA rights (except for newborns and newly adopted children of the employee).

Life. It is not a provision of COBRA, but if you end employment with the county (not if you retire or leave employment due to a disability), you may be eligible to continue your coverage through the portability feature of the policy (see the Aetna Life Insurance booklet for additional details on portability or converting your coverage).

► Making Changes under COBRA

If you notify AAI (King County's COBRA administrator), you may:

- Drop dental and vision and retain medical coverage anytime (notice must be received by AAI in the month before you want the change to become effective)
- Drop yourself and family members from coverage anytime (notice must be received by AAI in the month before you want the change to become effective)
- Add new eligible family members to your health coverage when a qualified change in status occurs (see "Changes You May Make When a Qualifying Event Occurs" in this booklet)
- Change medical plans during open enrollment
- Change medical plans between open enrollments if you move out of your current plan's coverage area and provide proof of your new permanent address, and another King County plan offers coverage in your new location.

► When COBRA Coverage Ends

COBRA coverage ends the:

- Last day of the month you or your family member fails to make the required payments within 30 days of the due date, becomes entitled to Medicare benefits after electing COBRA, reaches the end of your maximum COBRA coverage period or is no longer disabled as determined by Social Security and has exhausted designated months of COBRA coverage
- Day the plan terminates or you first become covered under another group health plan after the date of your COBRA election (unless the plan limits or excludes coverage for a preexisting condition of the individual continuing coverage)

If you die, your covered family members may extend their COBRA coverage up to 36 months from the date their COBRA coverage started.

The Health Insurance Portability and Accountability Act (HIPAA) restricts the extent group health plans may impose preexisting condition limits:

- If you become covered by another group plan and that plan contains a preexisting condition limit that affects you, your COBRA continuation coverage cannot be terminated. However, if the other plan's preexisting rule doesn't apply to you, your COBRA continuation coverage will be terminated.

- You do not have to show you are insurable to choose COBRA continuation coverage. However, COBRA continuation coverage is subject to your eligibility for coverage; King County reserves the right to terminate your coverage retroactively if you are determined ineligible.

You may be entitled to purchase an individual conversion policy when you are no longer covered under the county's plan. An individual conversion policy usually provides different coverage from your group coverage; some benefits you have now may not be available. Also, a conversion policy may cost more than your current coverage.

Retiree Benefits

► Retiree Benefit Eligibility

County-paid coverage ends the last of the month you retire. You may self-pay to continue medical and vision coverage (but not dental) if you:

- Have county benefits on your last day of employment
- Have worked for King County for at least five consecutive years before you retire
- Are not eligible for Medicare
- Are not covered under another medical group plan
- Meet the requirements for formal service or disability retirement under the Washington State Public Employees Retirement Act or the City of Seattle Retirement Plan (which applies only if you elected to remain under the City of Seattle system according to a formal agreement between King County and the City of Seattle).

Covered family members are eligible for continued coverage under your retiree benefits if they're not eligible for Medicare and meet the same eligibility requirements in effect when you were an active employee. Dental, life, AD&D and LTD coverage is not available under retiree benefits.

Retiree benefits are an alternative to COBRA; if you elect retiree benefits, you waive your COBRA rights. Consider these differences in choosing between retiree and COBRA benefits:

	Retiree Benefits	COBRA
Health coverage available	Medical and vision	Medical, dental and vision
Length of time coverage is available	Until you become eligible for Medicare	18 months maximum (29 months if you leave employment due to a disability as determined by Social Security)
Allowed to change medical plans between open enrollments	No	Yes, if you relocate out of your current plan's coverage area and notify AAI with proof of your new permanent address and availability of coverage under another King County plan in your new location

If you are participating in a Health Care Flexible Spending Account when you become eligible for retiree benefits or COBRA, you may continue participating through the end of the calendar year (see the Flexible Spending Accounts booklet).

► Retiree Benefit Enrollment

Your retirement is reported to Benefits and Retirement Operations through your termination notice or payroll report. Benefits and Retirement Operations then notifies Associated Administrators Inc. (King County's retiree benefit administrator), who contacts you regarding benefit plan options.

You have 60 days after coverage ends to make retiree elections or, if later, 60 days from the date of the AAI letter notifying you of your options. If you elect retiree benefits, you must make the initial premium payment by the 45th day after your election. Thereafter, all premiums are due the first of the month; coverage automatically ends if payment is not made within 30 days after the payment due date. AAI will give you payment information.

Because retiree benefit coverage is retroactive, there is no lapse in coverage – self-paid benefits begin when county-paid benefits end, even if retroactive processing and payments are required. Your initial payment must include all applicable back premiums.

► Retiree Benefit Options

If you elect retiree benefits, you self-pay to continue the same health coverage you had on your last day of employment. Your options for retiree coverage include:

- Medical and vision
- Medical only.

When you elect retiree benefits, you may continue covering the same family members who were covered the last day of your employment. If you do not continue covering the same family members, they have their own COBRA rights. If you continue covering the same family members under your retiree benefits and they cease to be eligible for retiree benefits, your family members have COBRA rights only if there is a qualifying event (see "COBRA" in this booklet).

► Making Changes under Retiree Benefits

If you notify AAI, you may:

- Drop vision and retain medical coverage anytime (notice must be received by AAI in the month before you want the change to become effective)
- Drop yourself and family members from coverage anytime (notice must be received by AAI in the month before you want the change to become effective)
- Add new eligible family members to your health coverage when a qualified change in status occurs (see "Changes You May Make When a Qualifying Event Occurs" in this booklet)
- Change medical plans during open enrollment.

► When Retiree Benefit Coverage Ends

Retiree benefits end the:

- Last day of the month you fail to make the required payments within 30 days of the due date or become entitled to Medicare after electing retiree benefits, or
- Day the plan terminates, you die or you first become covered under another group health plan after the date of your retiree benefit election (unless the plan limits or excludes coverage for a preexisting condition of the individual continuing coverage).

Federal laws restrict the extent group health plans may impose preexisting condition limits:

- If you become covered by another group plan and that plan contains a preexisting condition limit that affects you, your retiree coverage cannot be terminated. However, if the other plan's preexisting rule doesn't apply to you, your retiree coverage will end.
- You do not have to show you are insurable to choose retiree coverage. However, retiree benefits are subject to your eligibility for coverage; King County reserves the right to end your coverage retroactively if you are determined ineligible.

► If You Return to Work in a Benefit-Eligible Position

Your Washington State Department of Retirement Systems plan may allow you to return to work at King County after you retire while continuing to draw your pension benefits (certain restrictions apply; contact the Department at the number in the Resource Directory booklet).

If you return from retirement to work in a benefit-eligible position, you receive the same coverage a regular or part-time Local 587 employee in the position receives. During this return-to-work period, the premiums you pay for retiree benefits are suspended. When the work period ends, you have the option of resuming your retiree benefits. If you return as a part-time Local 587 employee in Plan 1 you must pay a portion of monthly premiums.

Anytime you fail to meet eligibility requirements (for instance, you don't work the required number of hours in a month) or when you leave post-retirement employment, you resume paying the full cost of your retiree benefits. You must contact AAI to resume your retiree benefits.

If You Leave Employment to Perform Uniformed Service

You need to provide your supervisor, personnel representative and Benefits and Retirement Operations with written notice and a copy of your orders both when you leave employment to perform uniformed service (such as in the military) and when you return to employment after uniformed service. While performing uniformed service your benefit coverage may be continued, depending on the circumstances.

If you leave employment to serve in the military or are called to active duty, you may be eligible for benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and King County Ordinance 13377. Call Benefits and Retirement Operations for more information.

If You're on a Mutual Aid Assignment

Occasionally, for instance in the case of a natural disaster, you may be asked to work temporarily for another agency in need of extra help. If you need health care while you're working in this situation, you will not pay more for the care because you're outside your usual area. Submit claims directly to the Manager of Benefits and Retirement Operations for processing and payment.

If you are on loan to a Borrower under the Northwest Mutual Aid Group Omnibus Agreement, you will continue to be covered under your regular medical, dental and vision plan. If, as a result of this arrangement, you receive services outside of the normal network area covered by your plan, your care will be covered by the county at the network level.

If You Enter Into a Labor Dispute

If you enter into a labor dispute, your King County coverage ends. If your pay is suspended directly or indirectly as a result of a strike, lockout or other labor dispute, you may be able to continue your benefit coverage temporarily by paying the full cost through COBRA:

- Medical, dental and vision coverage for up to 18 months (you may also continue participating in a Health Care FSA by contributing on an after-tax basis; see the Flexible Spending Accounts booklet)
- Life insurance for up to 12 months
- AD&D coverage for up to six months.

It may be possible to continue benefit coverage longer than indicated above if you convert from county group coverage to an individual plan. Check with each plan (see the Resource Directory booklet) for details.

If You or a Covered Family Member Dies

► If You Die

If you die while a participant in King County benefit plans, your family/beneficiaries must provide a death certificate to Benefits and Retirement Operations. When that occurs, Benefits and Retirement Operations will assist your family/beneficiaries with:

- Completing a claim for any life insurance, accidental death insurance or disability survivor benefit they're entitled to receive (see the respective plan booklets; if death is due to accident, the accident report is required)
- Understanding COBRA and options for continuing the health coverage they had through you
- Submitting claims for reimbursement under an FSA if you were enrolled
- Contacting the:
  - King County Employees Deferred Compensation Plan coordinator
  - Washington State Department of Retirement Systems
- Receiving the final paycheck
- Counseling and referral through the Making Life Easier Program.

► If a Family Member Dies

If your family member dies while you are a participant in King County benefit plans, contact Benefits and Retirement Operations for assistance with:
- Completing a claim for any life or accidental death insurance benefit you're entitled to receive (death certificate is required; if death is due to accident, accident report is also required)
- Completing other benefit forms as required
- Making benefit changes as appropriate
- Counseling and referral through the Making Life Easier Program.

Assignment of Benefits

Plan benefits are available to you and your covered family members only. In general, they cannot be assigned (or given away) to another person and are not subject to attachment or garnishment. However, there are exceptions; for details contact Benefits and Retirement Operations.

In paying for services, the plans may, at their option, make the payment to you, the provider or another carrier. The plans also will make payments on behalf of an enrolled child to his or her non-enrolled parent or a state Medicaid agency when required to do so by federal or state law. In these cases, the plans also have the right to make joint payments.

All payments are subject to applicable federal and state laws and regulations. Payments made according to this section will discharge the plans to the extent of the amount paid, so that the plans will not be liable to anyone aggrieved by their choice of payee.

Third Party Claims

If you receive benefits for any condition or injury for which a third party is liable, the plans may have the right to recover the money they paid for benefits. This means the plans are not obligated to pay for services necessary because of an injury or condition for which you may have other recovery rights unless or until you (or someone legally qualified and authorized to act for you) promises in writing to:
- Include those amounts in any claim you or your representative makes for the injury or condition
- Repay the applicable plan those amounts to the extent the proceeds of your recovery for the injury or condition exceed the total loss, prorating any attorneys' fees incurred
- Cooperate fully with the plans in asserting their rights by supplying all information and executing all documents reasonably needed for that purpose.

Any sums collected by or for you or your covered family members by legal action, settlement or otherwise on account of these benefits are payable to the plans only after and to the extent they exceed the amount required to fully compensate your loss.

This provision does not apply to life, accidental death and dismemberment, and long term disability.

Recovery of Overpayments

The plans have the right to recover amounts they paid that exceed the amount for which they are liable. These amounts may be recovered from one or more of the following (to be determined by the plans):

- Persons to or for whom the payments were made
- Other insurers
- Service plans
- Organizations or other plans.

These amounts may be deducted from your future benefits (or your family members' benefits, even if the original payment was not made on that family member's behalf).

The plans' right of recovery includes benefits paid in error due to any false or misleading statements made by you or your family members.

The LTD plan has a separate overpayment reimbursement policy and process (see the plan certificate for details).

Termination and Amendment of the Plans

The county fully intends to continue plan benefits indefinitely, but also reserves the absolute right to amend or terminate the plans for any reason at any time. If the county amends or terminates the plans, bona fide claims incurred before the amendment or termination will be paid.

LTD. Your right to receive LTD benefits for a period of disability that begins while you're covered will not be affected by plan amendment or termination, or termination of your coverage.

Your Patient Rights

► Dignity and Respect under Your Health Plans

You have the right to:

- Be treated with consideration, dignity and respect. You also have the responsibility to respect the rights, property and environment of all providers and other patients.
- See your own health records and to have those records kept private and confidential unless required to settle a claim, for plan operations, payment of claims, and as required by law.

You have these rights regardless of your gender, race, sexual orientation, marital status, culture or economic, educational or religious background.

► Knowledge and Information Concerning Your Health Plans

You have the right – and the responsibility – to know about and understand your health care and your coverage, including:

- Names and titles of all providers involved in your care
- Your health condition and status
- Services and procedures involved in your treatment
- Ongoing health care you need once you're discharged or leave the provider's office
- How the plans work (see the appropriate plan booklets)
- Any medication prescribed for you – what it is, what it's for, how to take it properly and possible side effects.

You also have the right to take an active part in decisions about your care. Once you participate in and agree to a treatment plan, you are responsible for following that plan or telling your provider otherwise.

► Continuous Improvement of Your Health Plans

You have the right to:
- Call or write with any questions or concerns and make suggestions for improving the plans
- Ask your providers to explain or give you more information about any health advice or prescribed treatment
- Appeal any health care or administrative decisions (see "Appealing a Claim" in the individual plan booklets).

► Privacy Protection

To protect your privacy, King County and your plans will use only the last four digits of your Social Security number (or no number at all) or a unique identifier number on ID cards, explanations of benefits or any other correspondence sent to you.

► Medical Plan Participant Accountability and Autonomy

As a partner in your own health care, you have the right to:
- Refuse treatment – as long as you accept the responsibility and consequences of that decision
- Complete an advance directive, such as a living will or durable power of attorney, for care
- Refuse to take part in any health care research projects
- Be advised on the full range of treatment options (whether covered under the plans or not) and their potential risks, benefits and costs
- Make the final choice among treatment alternatives.

You're also responsible to:
- Identify yourself and covered family members to providers when you receive services by showing your plan ID card (if provided by your plan) or providing your complete Social Security numbers (or unique identifier numbers if issued by the plan)
- Give your current provider all previous and relevant health care records and submit accurate, complete health information to all physicians or other providers involved in your care
- Be on time for appointments and let your provider's office know as far in advance as you can if you need to cancel or reschedule
- Follow instructions given by those providing your care
- Send copies of claim statements or other documents if requested
- Let your medical plan and primary care provider (if applicable) know within 24 hours, or as soon as reasonably possible, if you receive emergency care or out-of-area urgent care
- Tell the plan and your primary care provider (if applicable) about planned health care treatment, such as a surgery or an inpatient stay
- Pay all required copayments when you receive health care.

If you decide to give someone else the legal power to make decisions about your health care, that person also will have all of these rights and responsibilities.

Booklet 2

KingCare Basic and Preferred Medical

Aetna
Medical Services

AdvancePCS
Prescription Drug Services

Although these benefit descriptions include certain key features and brief summaries of King County regular employee and part-time Local 587 benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

Table of Contents: KingCare Basic and Preferred Medical

Overview

► Highlights of Coverage under the KingCare Basic and Preferred Medical Plans

Here are a few highlights of your coverage under the KingCare Basic and Preferred Plans:

- Two separate companies process claims for the plans:
  - Aetna processes all medical claims (physician visits, hospital, lab work, etc.)
  - AdvancePCS processes all outpatient, retail pharmacy and mail order prescription drug claims
- For medical services, you pay an annual deductible before the plans pay for most benefits, then you pay coinsurance for most services
- For prescription drug services:
  - You pay copays for each prescription filled (copays are lowest for generic drugs, higher for preferred brand drugs and highest for non-preferred brand drugs)
  - You may get up to 30-day supplies of prescription drugs at retail pharmacies and up to 90-day supplies through the AdvancePCS mail order service
- For both medical and prescription drug services:
  - Nationwide networks of providers are available but you may use non-network providers
  - When you use network providers your claims are filed automatically
  - When you use non-network providers you must file claims for reimbursement.

► Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just these plans and can change frequently. To be more efficient, and avoid repetition, the following related information appears only once – in the Important Facts booklet:

- Who's eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

See "Plan Features" for details on deductibles, copays and coinsurance amounts; also see the latest new hire guides and open enrollment materials or www.metrokc.gov/finance/benefits for information about any monthly coverage cost.

Medical Services. When you receive medical care, you pay:

- The annual deductible (does not apply to preventive care or hearing aids)
- Coinsurance amounts not covered by the plans
- Copays for emergency room care
- Amounts in excess of usual, customary and reasonable (UCR) rates if you use non-network providers
- Expenses for services or supplies not covered by the plans.

Prescription Drug Services. When you fill a prescription, you pay:

- Copays for up to a 30-day supply from a network pharmacy:
  - $10 for a generic drug
  - $15 for a preferred brand drug ($20 if generic available, but the $15 copay applies if you're unable to take generic for medical reasons)
  - $25 for a non-preferred brand drug ($30 if generic available, but the $25 copay applies if you're unable to take generic for medical reasons)

- Copays for up to a 90-day supply from the network mail order service:
  - $20 for a generic drug
  - $30 for a preferred brand drug ($40 if generic available, but the $30 copay applies if you're unable to take generic for medical reasons)
  - $50 for a non-preferred brand drug ($60 if generic available, but the $50 copay applies if you're unable to take generic for medical reasons)
- Amounts in excess of the rates AdvancePCS pays its network pharmacies if you use non-network pharmacies.

The annual deductible doesn't apply to prescription drugs.

Preexisting Condition Limit

There is no preexisting condition limit for medical or prescription drug services. However, there is a waiting period for transplants (see "Transplants" under "Covered Expenses under KingCare").

If you end employment with King County, please refer to "Certificate of Coverage" for information on how your participation in the KingCare plans can be credited against other plans with preexisting condition limits.

How the Plans Work

► Plan Features

The following table identifies some plan features, including your annual deductibles, out-of-pocket maximums and how benefits are determined for most covered expenses. The sections following the table contain additional details.

Plan Feature	KingCare Basic Plan	KingCare Preferred Plan
Provider choice	You may choose any qualified provider, but you receive higher coverage when you use network providers Reimbursement for non-network medical services is based on UCR rates, and reimbursement for non-network prescription drug services is based on the rates AdvancePCS pays its network pharmacies; you pay amounts in excess of these rates	You may choose any qualified provider, but you receive higher coverage when you use network providers Reimbursement for non-network medical services is based on UCR rates, and reimbursement for non-network prescription drug services is based on the rates AdvancePCS pays its network pharmacies; you pay amounts in excess of these rates
Annual deductible	$500/person, $1,500/family Deductible amounts applied to charges incurred in the last 3 months of the calendar year are carried over and applied to the next year's deductible Deductible doesn't apply to prescription drugs, preventive care or hearing aids	$100/person, $300/family Deductible amounts applied to charges incurred in the last 3 months of the calendar year are carried over and applied to the next year's deductible Deductible doesn't apply to prescription drugs, preventive care or hearing aids
Copays	Applicable only to emergency room care and prescription drugs (see "Summary of Covered Expenses" for amounts)	Applicable only to emergency room care and prescription drugs (see "Summary of Covered Expenses" for amounts)
After the deductible/copays, the plans pay most covered services at these levels ...	80% network for medical claims 60% non-network for medical claims 100% of network rate after applicable copays for prescription drug claims (deductible does not apply)	90% network for medical claims 70% non-network for medical claims 100% of network rate after applicable copays for prescription drug claims (deductible does not apply)

Plan Feature	KingCare Basic Plan	KingCare Preferred Plan
Until you reach your annual out-of-pocket maximum…	$1,200/person, $2,400/family for network care $2,000/person, $4,000/family for non-network care Does not apply to prescriptions; see "Annual Out-of-Pocket Maximum" for details	$800/person, $1,600/family for network care $1,600/person, $3,200/family for non-network care Does not apply to prescriptions; see "Annual Out-of-Pocket Maximum" for details
Then, most benefits are paid for the rest of the calendar year at …	100% for network services and 100% of UCR for non-network services	100% for network services and 100% of UCR for non-network services
Lifetime maximum	$2,000,000	$2,000,000

► Network Providers

Medical Services. Aetna is solely responsible for determining which providers participate in its nationwide network. For the KingCare plans, Aetna includes the Ethix network of Puget Sound providers in addition to its regular nationwide network of hospitals, clinics, doctors and other health care professionals. (Non-network providers may contact Aetna to join the Aetna network.)

All network hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations and have a current state license as well as adequate liability insurance. Doctors or other health care professionals meet credentialing requirements including completion of a detailed application that covers education, status of board certification, malpractice and state sanction histories.

For a list of Aetna network providers, contact Aetna (see Resource Directory booklet).

Prescription Drug Services. AdvancePCS contracts with pharmacies that participate in its nationwide network. The network includes all major chain pharmacies and most independent pharmacies, plus a mail order service.

For a list of AdvancePCS network pharmacies, contact AdvancePCS (see Resource Directory booklet).

► Out-of-Area Coverage

For both medical and prescription drug services, nationwide networks are available. Therefore, even when you're out of the area, you may use network providers and pharmacies to receive network coverage almost anywhere.

You may also use non-network providers when you're out of the area. However, when you choose non-network providers you must file your own claims. For medical claims you're reimbursed at UCR rates and for prescription drug claims you're reimbursed at the rates AdvancePCS pays its network pharmacies; you pay amounts non-network providers or pharmacies charge in excess of these rates.

► Annual Deductible

The annual deductible is the amount you must pay each year toward covered benefits before a plan starts paying. The annual deductible for:

- KingCare Basic is $500/person to a maximum of $1,500/family
- KingCare Preferred is $100/person to a maximum of $300/family.

The deductible does not apply to certain covered services and supplies, which means your plan pays for them even if you haven't met the deductible. These include prescription drugs (which require copays), preventive care and hearing aids.

If three or more family members (including yourself) together incur $1,500 in covered expenses for the KingCare Basic Plan ($300 for the KingCare Preferred Plan), you meet the family deductible. This means no further deductible will be required from any family member for the rest of that year.

If you and your family members are in the same accident, only one individual deductible will apply.

The amount you pay toward your deductible during the last three months of any calendar year will also apply toward next year's deductible.

► Annual Out-of-Pocket Maximum

The out-of-pocket maximum applies only to medical services; it does not apply to prescription drug services.

The out-of-pocket maximum is the most you pay in coinsurance for covered medical expenses each year. This means once you reach your out-of-pocket maximum, your KingCare plan pays 100% for most covered expenses for the rest of that year. If you have three or more family members (including yourself), each family member's covered expenses accumulate toward the family out-of-pocket maximum.

The following do not apply to the out-of-pocket maximum:
- Amounts in excess of UCR
- Annual deductible
- Charges beyond benefit maximums
- Coinsurance for smoking cessation programs and outpatient mental health care
- Copay amounts for emergency room care and prescription drugs
- Expenses not covered under the plans.

► Lifetime Maximum

The lifetime maximum applies only to medical services; there is no lifetime maximum for prescription drug services.

The total amount paid for all medical services under the KingCare Basic Plan or the KingCare Preferred Plan is limited to a lifetime maximum of $2,000,000. Up to $20,000 of this maximum is restored automatically at the start of each calendar year for benefits paid during the prior year. Some expenses are also subject to annual or lifetime benefit limits (see "Covered Expenses under KingCare").

► Accessing Care

Medical Services. You may receive network benefits or non-network benefits; the level of coverage depends on the provider you see.

For network benefits:
- You choose an Aetna network provider
- Your network provider obtains preauthorization from Aetna for certain procedures and services
- Your provider files your claims and Aetna reimburses the provider
- You receive an explanation of benefits (EOB) from Aetna, informing you of applicable deductibles, coinsurance and copays and indicating your share of the cost
- You receive a bill from your network provider and pay the provider the amount indicated on EOB.

For non-network benefits:
- You choose a non-network provider
- You must obtain preauthorization from Aetna for certain procedures and services (see "Obtaining Preauthorization")
- You may be required to pay the bill in full and file a claim for reimbursement from Aetna

- Aetna reimburses you based on the non-network benefit at UCR rates; any amount in excess of the UCR rate is your responsibility.

Prescription Drug Services. You may receive network benefits or non-network benefits; the level of coverage depends on the pharmacy you use.

For network benefits:
- You choose an AdvancePCS network pharmacy or the AdvancePCS mail order service
- Your doctor obtains preauthorization for certain prescription drugs and quantities from AdvancePCS
- You pay the appropriate copays to your network pharmacy or AdvancePCS mail order service when you fill your prescriptions
- AdvancePCS pays the pharmacy or processes the claim through its mail order service.

For non-network benefits:
- You choose a non-network pharmacy (there is no non-network mail order service)
- Your doctor obtains preauthorization for certain prescription drugs and quantities from AdvancePCS
- You pay the cost of the prescription in full and file a claim for reimbursement from AdvancePCS
- AdvancePCS reimburses you at the rate it would pay a network pharmacy, less the appropriate copay; any amount in excess of this rate is your responsibility.

► Second Opinions

On occasion, you may want a second opinion from another doctor. To receive network benefits, you must get the second opinion from an Aetna network provider. At any point, you may decide to see a non-network provider and receive non-network benefits.

► Obtaining Preauthorization

Medical Services. If you see an Aetna network provider, the provider will obtain preauthorization for your care as required. If you see a non-network provider, you are responsible for obtaining preauthorization for certain services or supplies. This means you must call or ask your physician to call for preauthorization on your behalf. You may then call Aetna to check that your physician followed through (see Resource Directory booklet).

With preauthorization, benefits will be paid according to plan provisions and limits, if your benefits are in force when you receive care. Aetna will confirm the preauthorization in writing. It will be valid for three months, if your condition does not change.

If you see a non-network provider, you must obtain preauthorization for these covered services:
- Anorexiants for treatment of attention deficit disorder or narcolepsy
- Durable medical equipment
- Growth hormones
- Home health care
- Hospice care
- Injectable prescription drugs (with certain exceptions like insulin, Depo-Provera and some others)
- Inpatient chemical dependency treatment
- Inpatient hospital care (other than for most stays in connection with childbirth)
- Inpatient mental health care
- Inpatient neurodevelopmental therapy for children age six and younger
- Skilled nursing facility care
- TMJ disorders
- Transplants.

If you are having surgery or being admitted to a hospital (except for childbirth), Aetna must be notified at least seven days before the (non-emergency) surgery or admission. Before admission, be sure to confirm with the hospital that your stay has been preauthorized.

You must call Aetna within 48 hours from the start of your care (or as soon as reasonably possible) for:
- Accidents
- Emergencies (including detoxification)
- Involuntary commitment to a Washington state mental hospital
- Maternity admissions.

To obtain preauthorization for non-emergency care (or certification afterward), have your physician contact Aetna at 1-800-654-7714. For chemical dependency treatment or mental health care, you may also call King County's Making Life Easier Program (see Resource Directory booklet). Staff will obtain preauthorization as necessary and refer you to a provider for treatment.

When calling, be prepared to supply these details:
- Admission date
- Diagnosis or surgery
- Employer name (King County)
- Employee name and Social Security number (or unique identifying number if assigned one by the plan)
- Hospital name and address or phone number
- Patient name, address and date of birth
- Physician name and address or phone number
- Proposed treatment plan, including length of stay and discharge planning needs.

If your care is not preauthorized as described above and Aetna determines your care was not medically necessary, the charges for your care may be only partially paid or may not be paid at all.

Prescription Drug Services. Certain prescriptions and quantities require preauthorization. You or your doctor can find out if preauthorization is required by contacting AdvancePCS (see Resource Directory booklet) before you have a prescription filled. Otherwise, your pharmacist or the AdvancePCS mail order service will advise you of the preauthorization procedures required to fill the prescription.

To preauthorize a prescription, your doctor or his/her representative must initiate the process with a phone call to AdvancePCS. Your eligibility is then confirmed and your prescription records checked to see if the prescription has been preauthorized before.

Preauthorization requests are evaluated using criteria approved by your plan; the request is then approved, denied or held for further information. If more information is required, AdvancePCS will notify your physician's office; once the doctor provides the information, your request can be approved or denied.

If the preauthorization is approved, AdvancePCS notifies your physician and updates its database so you can fill the prescription.

If preauthorization is denied, a pharmacist verifies the denial is valid according to plan criteria and then AdvancePCS notifies:
- Your physician verbally
- You and your physician in writing.

When you receive a written denial you may appeal (see "Appealing Denied Claims" in this booklet).

► Case Management

Medical Services. When determined medically necessary as well as care- and cost-effective, Aetna may offer or approve other benefit options on a case-by-case basis. These alternative options will be approved only when traditional benefits would otherwise be available under these plans. For example, when provided at equal or lesser cost, benefits could be available for home health care (instead of hospitalization or other institutional care) by a licensed home health, hospice, or home care agency.

Less expensive or less intensive services will be approved for alternative options only with your consent and when your physician confirms the services are adequate. An approved written treatment plan may be required.

The decision to offer or approve other benefit options remains with Aetna and will be determined based on individual medical needs. The amount of coverage for approved alternative options will not exceed the amount that would otherwise be available for approved traditional benefits.

Prescription Drug Services. AdvancePCS does not determine the maximum number of refills or period when a prescription is valid; these requirements are mandated by federal and state laws regulating pharmacy practices. However, certain drugs must be preauthorized by Advance PCS before they will be covered:

- Attention deficit disorder/narcolepsy medication for patients over age 18
- Growth hormones
- Multiple sclerosis medication
- Oral antifungal medication
- Topical acne medication for patients over 24.

AdvancePCS routinely reviews prescribing guidelines to ensure drugs are clinically appropriate and may limit the quantities of certain drugs to ensure proper utilization. For a list of these drugs, contact AdvancePCS (see the Resource Directory booklet).

Covered Expenses under KingCare

► Summary of Covered Expenses

The following table summarizes covered services and supplies under these plans (only medically necessary services, prescription drugs and supplies are covered) and identifies related coinsurance, copays, maximums and limits. Also see the sections after the table as well as "Expenses Not Covered."

Aetna processes medical claims, AdvancePCS processes outpatient, retail pharmacy and mail order prescription drug claims and, where a benefit involves claims processed by both companies, the information is noted in the following table or in the sections that follow the table.

Covered Expenses	KingCare Basic Plan	KingCare Preferred Plan
Alternative care (including medically necessary acupuncture, hypnotherapy, massage therapy and naturopathy)	80% network 60% non-network Certain services must be prescribed by a physician; Aetna reviews medical necessity of all treatment after 20 visits	90% network 70% non-network Certain services must be prescribed by a physician; Aetna reviews medical necessity of all treatment after 20 visits
Ambulance services	80%	90%
Chemical dependency treatment (requires preauthorization)	80% network 60% non-network $11,285 maximum in 24 consecutive months for combined network and non-network services (maximum subject to annual adjustment)	100% network 70% non-network $11,285 maximum in 24 consecutive months for combined network and non-network services (maximum subject to annual adjustment)
Chiropractic care and manipulative therapy (like all services, must be medically necessary)	80% network 60% non-network Up to 33 visits/year for combined network and non-network services Limited to diagnosis and treatment of musculoskeletal disorders	90% network 70% non-network Up to 33 visits/year for combined network and non-network services Limited to diagnosis and treatment of musculoskeletal disorders

Covered Expenses	KingCare Basic Plan	KingCare Preferred Plan
Circumcision (covered within 31 days of birth; after 31 days if medically necessary)	80% network 60% non-network	90% network 70% non-network
Diabetes care training	80% network when prescribed by your physician 60% non-network when prescribed by your physician	90% network when prescribed by your physician 70% non-network when prescribed by your physician
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs	Covered under prescription drugs
Durable medical equipment, prosthetics and orthopedic appliances	80% when preauthorized	80% when preauthorized
Emergency room care	80% after $50 copay/visit (waived if admitted) for network or non-network emergency care 80% network, 60% non-network after $50 copay/visit for non-emergency care	90% after $50 copay/visit (waived if admitted) for network or non-network emergency care 90% network, 70% non-network after $50 copay/visit for non-emergency care
Family planning	80% network 60% non-network	90% network 70% non-network
Growth hormones	80% network when preauthorized 60% non-network when preauthorized May also be covered under the prescription drug benefit	90% network when preauthorized 70% non-network when preauthorized May also be covered under the prescription drug benefit
Hearing aids	100% up to $500 in 36 months for combined network and non-network services Deductible does not apply	100% up to $500 in 36 months for combined network and non-network services Deductible does not apply
Home health care	100% when preauthorized up to 130 visits/year for combined network and non-network services	100% when preauthorized up to 130 visits/year for combined network and non-network services
Hospice care	100% when preauthorized 6-month lifetime maximum 120-hour maximum for respite care in any 3-month period	100% when preauthorized 6-month lifetime maximum 120-hour maximum for respite care in any 3-month period
Hospital care	80% network when preauthorized 60% non-network when preauthorized	90% network when preauthorized 70% non-network when preauthorized
Infertility	80% network 60% non-network Limited to specific services and $25,000 lifetime maximum for combined network and non-network services	90% network 70% non-network Limited to specific services and $25,000 lifetime maximum for combined network and non-network services
Injury to teeth	80% network 60% non-network Up to $600/accident for combined network and non-network services	90% network 70% non-network Up to $600/accident for combined network and non-network services
Inpatient care alternatives	80% network when preauthorized 60% non-network when preauthorized	90% network when preauthorized 70% non-network when preauthorized

Covered Expenses	KingCare Basic Plan	KingCare Preferred Plan
Lab, x-ray and other diagnostic testing	80% network 60% non-network	90% network 70% non-network
Massage therapy (see "Alternative care")	80% network 60% non-network	90% network 70% non-network
Maternity care	80% network 60% non-network	90% network 70% non-network
Mental health care (when deemed appropriate, 2 unused outpatient visits may be traded for 1 inpatient day, or vice versa; requires preauthorization)	80% network, 60% non-network for inpatient up to 30 days/year (combined network and non-network services) 50% up to 52 visits/year for outpatient (combined network and non-network services)	90% network, 70% non-network for inpatient up to 30 days/year (combined network and non-network services) 50% up to 52 visits/year for outpatient (combined network and non-network services)
Neurodevelopmental therapy for family members age 6 and under	80% network when preauthorized 60% non-network when preauthorized $2,000/year maximum for combined network and non-network services	90% network when preauthorized 70% non-network when preauthorized $2,000/year maximum for combined network and non-network services
Out-of-area coverage while traveling, for your children away at school, etc.	Same coverage as when home, through Aetna and AdvancePCS national provider networks	Same coverage as when home, through Aetna and AdvancePCS national provider networks
Physician and other medical/surgical services	80% network 60% non-network	90% network 70% non-network
Phenylketonuria (PKU) formula	80% network 60% non-network	90% network 70% non-network
Prescription drugs – up to 30-day supply through network pharmacies	100% after $10 copay for generic 100% after $15 copay for preferred brand ($20 if generic available, but if unable to take it for medical reasons, the $15 copay applies) 100% after $25 copay for non-preferred brand ($30 if generic available, but if unable to take it for medical reasons, the $25 copay applies) Prescriptions filled at non-network pharmacies reimbursed at the rate AdvancePCS pays to network pharmacies, less your copay	100% after $10 copay for generic 100% after $15 copay for preferred brand ($20 if generic available, but if unable to take it for medical reasons, the $15 copay applies) 100% after $25 copay for non-preferred brand ($30 if generic available, but if unable to take it for medical reasons, the $25 copay applies) Prescriptions filled at non-network pharmacies reimbursed at the rate AdvancePCS pays to network pharmacies, less your copay
Prescription drugs – up to 90-day supply through mail order network only	100% after $20 copay for generic 100% after $30 copay for preferred brand ($40 if generic available, but if unable to take it for medical reasons, the $30 copay applies) 100% after $50 copay for non-preferred brand ($60 if generic available, but if unable to take them for medical reasons, the $50 copay applies)	100% after $20 copay for generic 100% after $30 copay for preferred brand ($40 if generic available, but if unable to take it for medical reasons, the $30 copay applies) 100% after $50 copay for non-preferred brand ($60 if generic available, but if unable to take them for medical reasons, the $50 copay applies)

Covered Expenses	KingCare Basic Plan	KingCare Preferred Plan
Preventive care (well-child check-ups, immunizations, routine health and hearing exams, etc.)	100% network 60% non-network Deductible does not apply	100% network 70% non-network Deductible does not apply
Radiation therapy, chemotherapy and respiratory therapy	80% network 60% non-network	90% network 70% non-network
Reconstructive services (includes benefits for mastectomy-related services **–** reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema; call plans for more information)	80% network 60% non-network	90% network 70% non-network
Rehabilitative services Inpatient and outpatient	80% network 60% non-network	90% network 70% non-network
Skilled nursing facility	80% network when preauthorized 60% non-network when preauthorized	90% network when preauthorized 70% non-network when preauthorized
Smoking cessation	80% network services 60% non-network services $500 lifetime maximum for smoking cessation services and prescriptions combined (prescriptions covered under "Prescription drugs" benefit)	90% network services 70% non-network services $500 lifetime maximum for smoking cessation services and prescriptions combined (prescriptions covered under "Prescription drugs" benefit)
Temporomandibular joint (TMJ) disorders	80% network when preauthorized 60% non-network when preauthorized Nightguards covered if prescribed by a medical doctor for a TMJ disorder Up to $2,000/calendar year for combined network and non-network services	90% network when preauthorized 70% non-network when preauthorized Nightguards covered if prescribed by a medical doctor for a TMJ disorder Up to $2,000/calendar year for combined network and non-network services
Transplants (certain services only)	100% network when preauthorized 60% non-network when preauthorized Medical coverage must have been continuous for more than 12 months under a KingCare plan – whether preexisting or an emergency	100% network when preauthorized 70% non-network when preauthorized Medical coverage must have been continuous for more than 12 months under a KingCare plan – whether preexisting or an emergency
Urgent care (ear infections, high fevers, minor burns, etc.)	80% network 60% non-network	90% network 70% non-network

► Alternative Care

Covered services include:

- Acupuncture, limited to services for chronic pain symptoms
- Hypnotherapy for chronic pain control or services prescribed by a covered mental health provider specified under "Mental Health Care"
- Massage therapy prescribed by a physician and designed to restore and improve physical functioning lost due to an illness or injury covered under the rehabilitative or neurodevelopmental benefit
- Naturopathy (limited to physical exams, diagnosis, interpretation of lab tests, nutritional counseling for chronic diseases where dietary adjustment has a therapeutic role, and treatment of chronic conditions).

After 20 visits for any of the covered alternative care services listed, Aetna will request your medical records to determine the medical necessity of further treatment.

► Ambulance Services

These plans cover medically necessary emergency ground or air ambulance services to a network facility or the nearest facility where appropriate care is covered.

► Chemical Dependency Treatment

Aetna network providers obtain preauthorization for this care as necessary. If you see a non-network provider, you must obtain preauthorization from Aetna for inpatient chemical dependency treatment. For additional counseling and referral services, you may also call the King County Making Life Easier Program at 1-888-874-7290.

Chemical dependency benefits are covered up to $11,285 in plan payments in 24 consecutive months. (This maximum is effective in 2003 and may be adjusted each year; please refer to the latest new hire guides or open enrollment materials for the current maximum.)

Inpatient and outpatient chemical dependency treatment is covered, including:
- Detoxification services
- Diagnostic evaluation and education
- Organized individual and group counseling
- Prescription drugs and medicines.

Aetna processes claims for prescription drugs used during inpatient hospitalization; AdvancePCS processes claims for outpatient, retail pharmacy and mail order drugs.

► Chiropractic Care and Manipulative Therapy

The plans cover services of licensed chiropractors, up to 33 visits per year, limited to diagnosis and treatment of musculoskeletal disorders, including:
- Diagnostic lab services directly related to the spinal care treatment you are receiving
- Full spinal x-rays
- Non-invasive spinal manipulations.

The plans do not cover spinal manipulations under anesthesia.

► Diabetes Care Training

The plans cover diabetes care training when prescribed by your physician.

► Durable Medical Equipment, Prosthetics and Orthopedic Appliances

Durable medical equipment is covered if:
- Designed for prolonged use
- It has a specific therapeutic purpose in treating your illness or injury
- Prescribed by your physician, and
- Primarily and customarily used only for medical purposes.

Network providers will obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for durable medical equipment.

Medical Services. The following services are covered (Aetna processes the claims):
- Artificial limbs or eyes (including implant lenses prescribed by your provider and required as a result of cataract surgery or to replace a missing portion of the eye)
- Casts, splints, crutches, trusses or braces
- Diabetes equipment for home testing and insulin administration not covered under the prescription drug benefit (excluding batteries)
- Initial external prosthesis and bra necessitated by breast surgery and replacement of these items when required by normal wear, a change in medical condition or additional surgery
- Oxygen and rental equipment for its administration
- Penile prosthesis when impotence is caused by a covered medical condition, a complication directly resulting from a covered surgery or an injury to the genitalia or spinal cord and other accepted treatment has been unsuccessful (lifetime maximum of two prostheses)
- Rental or purchase (decided by Aetna) of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price)
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum of $100.

Prescription Drug Services. Some items are covered through AdvancePCS (see Prescription Drugs").

► Emergency Room Care

Emergency room care treats medical conditions that threaten loss of life or limb, or may cause serious harm to the patient's health if not treated immediately. Examples of conditions that might require emergency room care include, but are not limited to:
- Bleeding that will not stop
- Chest pain
- Convulsions
- Major burns
- Severe breathing problems
- Unconsciousness or confusion, especially after a head injury.

If you need emergency room care, follow these steps:
- Go to the nearest hospital emergency room immediately
- When you arrive, show your medical plan ID card
- If possible, call Aetna within 48 hours (the phone number is printed on the front of your ID card); otherwise, you may receive a lesser benefit (if you're unable to call, have a friend, relative or hospital staff person call for you).

If you have a medical emergency as determined by the plans, you receive network-level benefits for network or non-network care. If your condition does not qualify as a medical emergency, but care is urgently needed, see "Urgent Care."

► Family Planning

Medical Services. The following services are covered (Aetna processes the claims):
- Insertion of intrauterine birth control devices (IUDs)
- Tubal ligation
- Vasectomy
- Voluntary termination of pregnancy.

The KingCare plans do not cover:
- Procedures to reverse voluntary sterilization
- Sexual dysfunction treatment or related diagnostic testing.

Prescription Drug Services. Birth control pills and devices requiring a prescription are covered (AdvancePCS processes the claims).

► Growth Hormones

Growth hormones are covered for certain medical conditions and must be preauthorized if you receive network or non-network care. If you receive this drug from your provider, your provider bills Aetna for the drug and its administration. If you get the drug from a retail pharmacy or mail order service, AdvancePCS pays for the drug and Aetna pays for administration by your provider, if needed.

► Hearing Aids

Hearing aids (including fitting, rental and repair) are covered up to $500 per 36-month period.

► Home Health Care

Home health care services are covered if:
- Care takes the place of a hospital stay
- Part of a home health care plan, and
- Provided and billed by a licensed Washington State home health care agency.

Home health care is payable up to 130 visits per year. Network providers obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for home health care.

Covered services include:
- Nursing care
- Occupational therapy
- Physical therapy
- Respiratory therapy
- Restorative therapy
- Speech therapy (restorative only).

Services and prescription drugs provided and billed by a home infusion therapy company are also covered if the company is licensed by the state as a home health care agency. The prescription drug claims are processed by AdvancePCS when they're filled at a retail pharmacy or through the mail order service.

The following services are not covered:
- Custodial care, except by home health aides as ordered in the approved plan of treatment
- Housecleaning
- Services or supplies not included in the written plan of treatment
- Services provided by a person who resides in your home or is a family member
- Travel costs or transportation services.

► Hospice Care

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. The team may include a physician, nurse, medical social worker or physical, speech, occupational or respiratory therapist.

Hospice care services are covered up to six months if:
- Care takes the place of a hospital stay
- Part of a hospice care treatment plan, and
- Provided and billed by an organization licensed as a hospice by Washington State.

Network providers obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for hospice care.

Covered services include:
- Drugs and medications (Aetna processes claims for prescription drugs provided by the hospice during the course of medical treatment; AdvancePCS processes claims for retail pharmacy and mail order drugs)
- Emotional support services
- Family bereavement services
- Home health services
- Homemaker services
- Inpatient hospice care
- Physician services
- Respite care for family members who care for the patient.

An extension of these benefits may be granted by a written request from your physician to Aetna.

The following services are not covered:
- Any services provided by members of the patient's family
- Financial or legal counseling (examples are estate planning or the drafting of a will)
- Funeral arrangements
- Homemaker, caretaker or other services not solely related to the patient, such as:
  - House cleaning or upkeep
  - Sitter or companion services for either the plan participant who is ill or for other family members
  - Transportation
- More than 120 hours of respite care in any three months of hospice care
- Pastoral counseling.

► Hospital Care

Inpatient. Covered inpatient hospital care includes:
- Hospital services, such as
  - Anesthesia and related supplies administered by hospital staff
  - Artificial kidney treatment
  - Blood, blood plasma and blood derivatives
  - Drugs provided by the hospital in the course of medical treatment are covered through Aetna; outpatient, retail pharmacy and mail order drugs are covered through AdvancePCS
  - Electrocardiograms
  - Operating rooms, recovery rooms, isolation rooms, cast rooms
  - Oxygen and its administration
  - Physiotherapy and hydrotherapy
  - Splints, casts and dressings
  - X-ray, radium and radioactive isotope therapy
  - X-ray and lab exams
- Intensive care or coronary care units
- Newborn nursery care after covered childbirth, including circumcision
- Semiprivate room, patient meals, general nursing care (private room charges are covered only up to the hospital's semiprivate rate).

Network providers obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for inpatient care other than that necessary for up to 48 hours following a vaginal childbirth, 96 hours following a cesarean section.

If a hospital stay continues from one calendar year to the next, a second deductible is not required for further treatment before discharge. Coverage continues at 100% until discharge, if the out-of-pocket maximum is met for the year hospitalization began.

Convalescent, custodial or domiciliary care is not covered.

Outpatient. Covered outpatient care includes:
- Diagnostic and therapeutic nuclear medicine in a hospital setting
- Hospital outpatient chemotherapy to treat malignancies
- Outpatient surgery
- Surgery in an ambulatory surgical center in place of inpatient hospital care.

► Infertility

Covered infertility expenses include:
- Embryo transfer
- Intrauterine and intravaginal artificial insemination
- In vitro fertilization.

Infertility benefits are payable up to $25,000 for your lifetime.

The plans do not cover:
- Assisted reproductive technology (ART) methods not listed above
- Donor expenses
- Donor sperm and banking services
- Drugs to treat infertility
- Procedures to reverse voluntary sterilization
- Services for dependent children
- Sexual dysfunction.

► Injury to Teeth

The services of a licensed dentist are covered for repair of accidental injury to sound, natural teeth. Injuries caused by biting or chewing are not covered. Treatment must begin within 30 days of the accident, and all services must be provided within 12 months of the date of injury. This benefit is limited to $600 per accident.

► Inpatient Care Alternatives

Your physician may develop a written treatment plan for care in an equally or more cost-effective setting than a hospital or skilled nursing facility. If the alternative setting plan is approved by your KingCare plan, all hospital or skilled nursing facility (depending on what kind of care the alternative is intended to replace) benefit terms, maximums and limits apply to the inpatient care alternatives.

► Lab, X-ray and Other Diagnostic Testing

Covered services include:
- Lab or x-ray services, such as ultrasound, nuclear medicine, allergy testing
- Screening and diagnostic procedures during pregnancy as well as related genetic counseling (when medically necessary for prenatal diagnosis of congenital disorders)
- Services to diagnose or treat medical conditions of the eye by a physician or licensed optometrist; eyewear and routine vision exams and tests for vision sharpness are not covered under this benefit (see Vision Service Plan booklet for additional information).

"Preventive Care" in this booklet describes benefits for routine screenings such as hearing tests and mammograms.

► Maternity Care

Maternity care is covered if provided by a:
- Physician (a registered nurse whose specialty is midwifery is considered a physician for this purpose), or
- Provider licensed as a midwife by Washington State.

Covered maternity care includes:
- Complications of pregnancy or delivery
- Hospitalization and delivery, including home births and licensed birthing centers for low-risk pregnancies
- Postpartum care
- Pregnancy care
- Related genetic counseling when medically necessary for prenatal diagnosis of congenital disorders
- Screening and diagnostic procedures during pregnancy.

The plans do not cover:
- Home pregnancy tests
- Lamaze classes
- Maternity care for children.

Group medical plans and health insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not require that a provider obtain authorization for prescribing a length that doesn't exceed 48 hours (or 96 hours).

You don't need to preauthorize the length of stay unless it exceeds the 48 or 96 hours.

► Mental Health Care

Inpatient and outpatient mental health care is covered if provided by a licensed psychiatrist (MD), licensed psychologist (PhD), licensed master's level mental health counselor, licensed nurse practitioner (ARNP), community mental health agency licensed by the Department of Health or licensed state hospital.

Covered services include:
- Individual and group psychotherapy
- Inpatient care or day treatment care instead of hospitalization (must be in a licensed medical facility)
- Lab services related to the covered provider's approved treatment plan
- Marriage and family therapy
- Physical exams and intake history
- Psychological testing.

Depending on individual medical needs, other benefit options may be available under the medical case management provision of these plans (see "Case Management" in this booklet).

Inpatient mental health care is limited to 30 days per year. Outpatient mental health care is limited to 52 visits per year. When deemed appropriate by Aetna, two unused outpatient visits may be traded for one inpatient day, or vice versa. Network providers obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for inpatient mental health care. You also may receive these benefits by calling King County's Making Life Easier Program. A staff member will obtain preauthorization approval as necessary and refer you to a provider for treatment.

The plans do not cover:
- Biofeedback
- Custodial care

- Specialty programs for mental health therapy not provided by these plans
- Treatment of sexual disorders.

► Neurodevelopmental Therapy

The plans cover inpatient and outpatient neurodevelopmental therapy for covered family members age six and younger.

Neurodevelopmental therapy services are covered only if the care is:
- Furnished by providers authorized to deliver occupational therapy, speech therapy and physical therapy
- Prescribed by the patient's physician, and
- Provided because significant deterioration in the child's condition would result without such services, or to restore and improve function of the child.

Network providers obtain preauthorization for your care as necessary. If you see a non-network provider you must obtain preauthorization for inpatient neurodevelopmental therapy.

► Newborn Care

The plans cover newborns under the mother's coverage for the first three weeks, as required by Washington State law. To continue the newborn's coverage after three weeks, the newborn must be eligible and enrolled by the deadline as described in the Important Facts booklet.

► Physician and Other Medical/Surgical Services

The following services are covered (Aetna processes the claims):
- Immunization agents or biological sera, such as allergy serum
- Medical care in the provider's office
- Nutritional counseling by a licensed nutritionist or dietitian when medically necessary for disease management
- Physician services for surgery, anesthesia, home, office, hospital and skilled nursing facility visits
- Second opinions obtained before treatment (the provider giving the second opinion must be qualified, either through experience or specialist training); a second opinion may be required to confirm the medical necessity of a proposed surgery or treatment plan.

► PKU Formula

The plans cover the medical dietary formula that treats phenylketonuria (PKU) through Aetna.

► Prescription Drugs

Prescription drug services for KingCare members are provided by AdvancePCS, a separate provider not affiliated with Aetna. AdvancePCS issues a separate prescription card to KingCare members to use when filling prescriptions at AdvancePCS network pharmacies or from the AdvancePCS mail order service, AdvanceRx.com.

You may order up to a 30-day supply from a retail network pharmacy or up to a 90-day supply per prescription or refill through the mail order service (if you use the mail order service, you pay the 90-day copay amounts even if your prescription is written for less than a 90-day supply).

What's Covered. The following items are covered (Advance PCS processes the claims):
- Contraceptives (oral, injectable, vaginal, topical and implantable)
- Controlled substance 5 over-the-counter drugs (see Glossary booklet for a definition)
- DESI drugs (see Glossary booklet for a definition)
- Emergency allergic reaction kits
- Emergency contraceptives

- Glucagon emergency kit
- Injectable prescription drugs purchased at a retail pharmacy or through mail order (for some, preauthorization may be required; some injectables may be covered under medical services)
- Insulin and diabetic supplies
  - Alcohol swabs
  - Blood glucose testing strips
  - Glucose tablets
  - Injection devices (such as Novopen)
  - Insulin administered by pen/cartridge or other special injection devices
  - Insulin needles and syringes
  - Insulin/predrawn syringes
  - Keytone testing strips
  - Lancets
  - Lancet devices
  - Monitors
  - Urine glucose testing strips
- Legend drugs unless specified otherwise (see Glossary booklet for a definition)
- Ostomy supplies
- Prenatal vitamins
- Smoking cessation drugs requiring a prescription (claims for non-prescription nicotine patches are covered through Aetna and reimbursed at network rates)
- Topical smoking cessation patches whether prescription or over-the-counter
- Viagra, if used to treat impotency or penile dysfunction and preauthorized.

What's Not Covered. The following items are not covered by AdvancePCS:
- Anorexiants
- Any over-the-counter medication, unless otherwise noted
- Blood products
- Cosmetic/hair loss medications
- Experimental medications that do not have the 11-digit code assigned under FDA regulations
- Infertility medications
- Therapeutic devices or appliances, including hypodermic needles, syringes (except those used for insulin and in the course of administering medical treatment), support garments and other non-medical substances regardless of intended use
- Vitamins (except prenatal).

An extensive nationwide network of pharmacies has agreed to dispense covered prescription drugs to plan participants at a discounted cost and not to bill plan participants for any amounts over the copays.

Using a Network Pharmacy. Here's how it works:
- Choose a network pharmacy (contact AdvancePCS for a list of network pharmacies or to find one near you; see Resource Directory booklet)
- Show your AdvancePCS prescription card to the network pharmacist each time you want a prescription filled or refilled (your Aetna medical card is not used for prescription drug services)
- Pay the copay for each covered new prescription or refill
- There are no claim forms to submit; the network pharmacy bills the plan directly.

If you do not show your prescription card, and the network pharmacy cannot reach AdvancePCS to confirm you are covered, you will need to pay the pharmacy in full and submit a claim for reimbursement to AdvancePCS.

Using a Non-Network Pharmacy. If you fill a prescription through a non-network pharmacy, you must pay the cost of the prescription first and then submit a claim for reimbursement from AdvancePCS. Reimbursement is based on the rates AdvancePCS pays its network pharmacies. Generally, a non-network provider charges more than what AdvancePCS pays its network pharmacies. If so, you or your family members pay the difference.

Mail Order Service. The mail order service is for maintenance drugs (drugs you must take on an ongoing basis). The first time you use the mail order service, fill out the patient information questionnaire on the order form available at AdvancePCS.com or by calling AdvancePCS (see Resource Directory booklet). This questionnaire needs to be completed only once. The information is maintained by AdvancePCS and assists in cross-checking future medicines for drug allergies.

Each time you order a new prescription, send the order form with your payment directly to the address on the form. You must include your physician's written prescription with your order form and payment. Once you've submitted the order form, you may obtain refills through the AdvancePCS website or by calling the toll-free number on the back of your prescription card.

All prescriptions are processed promptly and are usually returned to you within 14 days. If you don't receive your medicine within 14 days or have questions, contact the mail order service through the Web or by phone.

If you use the mail order service, you pay the 90-day copay amounts even if your prescription is written for less than a 90-day supply. (There is no non-network mail order service.)

► Preventive Care

The following preventive care is covered:
- Breast exams, pelvic exams and Pap tests every year for women
- Immunizations, including annual flu shots (immunizations for travel are not covered)
- Mammograms every year for women over 40 (or as determined by provider for high-risk patients)
- Routine physicals and hearing tests.

Immunizations (well-baby), routine physicals and hearing tests are covered according to the following schedule. The schedule is a guideline; benefits may be available for more frequent care depending on the situation. Contact Aetna for details (see Resource Directory booklet).

Age	Preventive Care
Birth to 1 year	Routine newborn care plus 5 well-baby office exams
1- 5 years	4 well-child visits, with 1 visit in each of these age groups: 1-2, 2-3, 3-4, 4-5
6 - 12 years	3 well-child visits, with 1 visit in each of these age groups: 6-8, 8-10, 10-12
13 - 17 years	2 well-teen visits, with 1 visit between ages 13-15 and 1 visit between ages 15-17
18 - 25 years	1 well-adult visit
26 - 49 years	1 well-adult visit every 4 years
50 years and older	1 well-adult visit every 2 years

► Radiation Therapy, Chemotherapy and Respiratory Therapy

Inpatient and outpatient services are covered for medically necessary radiation, chemotherapy and respiratory therapy when prescribed by your physician.

► Reconstructive Services

Reconstructive surgery to improve or restore bodily function is covered, subject to the plans' review and approval. The plans do not cover cosmetic surgery to improve physical appearance unless it is medically necessary.

Covered individuals receiving benefits for a mastectomy who elect breast reconstruction in connection with the mastectomy, as determined in consultation with the patient and attending physician, have these benefits:

- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas
- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the healthy breast to produce a symmetrical appearance.

These reconstructive benefits are subject to the same annual deductible and coinsurance provisions as other medical and surgical benefits.

► Rehabilitative Services

The plans cover medically necessary inpatient and outpatient rehabilitative care designed to restore and improve a physical function lost due to a covered illness or injury. This care is considered medically necessary only if significant improvement in the lost function occurs while the care is provided and the attending physician expects significant improvement to continue. To verify whether coverage for rehabilitative services applies or continues to apply, Aetna has the right to obtain written opinions from the attending physician concerning whether and to what extent the significant improvement is occurring.

Inpatient services are covered to a maximum of 60 days per calendar year and must be in a licensed hospital or skilled nursing facility. Outpatient services are covered to a maximum of 60 visits for all therapies combined per calendar year and must be furnished by a licensed medical provider.

These plans do not cover services or expenses related to schools or other non-medical facilities that primarily supply educational, vocational, custodial and/or rehabilitative support training or similar services.

► Skilled Nursing Facility

Skilled nursing facility services are covered if:

- Provided and billed by a licensed Washington State skilled nursing facility, and
- The care takes the place of a hospital stay.

Let your provider know a written plan of treatment is required for these services to be covered. Network providers obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for skilled nursing facility care.

Prescription drugs are covered through Aetna when provided by the skilled nursing facility and used by the patient during a period of covered skilled nursing facility care; outpatient, retail pharmacy and mail order drugs are covered through AdvancePCS.

The following services are not covered:

- Custodial care
- Services or supplies not included in your physician's written plan of treatment
- Services provided by a person who resides in your home or is a family member
- Travel costs.

Skilled nursing facility confinement for developmental disability, mental conditions or primarily domiciliary, convalescent or custodial care is not covered.

► Smoking Cessation

These plans cover:

- Acupuncture to ease nicotine withdrawal
- Hypnotherapy to ease nicotine withdrawal
- Prescription drugs to ease nicotine withdrawal are covered through AdvancePCS; claims for non-prescription nicotine patches are covered through Aetna and reimbursed at network rates

- Smoking cessation programs (non-network benefits available only); to receive benefits for a smoking cessation program, you must complete the full course of treatment.

No medical plan benefits are provided for:
- Books or tapes
- Inpatient services
- Nicotine gum
- Vitamins, minerals or other supplements.

The lifetime maximum for smoking cessation is $500.

► TMJ Disorders

Diagnosis and treatment of temporomandibular joint disorder and myofascial pain (including nightguards when prescribed by a medical doctor due to a TMJ diagnosis) are covered as a medical condition up to $2,000 per calendar year. Non-network services must be preauthorized and in general use and acceptance by the medical/dental community to relieve symptoms, promote healing, modify behavior and stabilize the condition.

Additional benefits are available through the dental plan (see Washington Dental Service Plan booklet).

► Transplants

Covered services include professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery and follow-up care as well as certain donor expenses. Benefits may include travel and accommodations for a recipient's family member or parent and up to $100 a day for the family member's food and lodging if the care is provided out of state. These benefits are payable only until the family member's presence is no longer necessary, as determined by the plans.

Network providers obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for transplants.

You are not eligible for organ transplant benefits until the first day of the 13th month of continuous coverage under a KingCare plan whether or not the condition is preexisting or an emergency.

If your provider recommends a transplant (even if it's not listed in this section) call Aetna immediately to discuss your situation, determine if the transplant is covered and, if so, make the necessary arrangements.

The following human transplants are covered:
- Bone marrow including peripheral stem cell rescue
- Cornea
- Heart
- Heart-lung
- Kidney
- Liver
- Lung (single or double)
- Pancreas with kidney.

Transplant Recipients. If you are a transplant recipient, all of your services and supplies (including transportation to and from designated facilities) are covered. (Designated facilities are specific facilities identified by Aetna and authorized to perform certain transplant procedures for plan participants.) You must be accepted into the facility's transplant program and continue to follow that program's protocol.

Transplant Donor. Transplant donor expenses are covered if the recipient is a plan participant. Covered services include:

- Bone marrow testing and typing of the brothers, sisters, parents and children of the patient who needs the transplant; testing and typing of any other potential donor are not covered
- Evaluation of the donor organ or bone marrow, its removal and transport of both the surgical/harvesting team and donor organ or bone marrow (if used for a covered transplant)
- Locating a donor, such as tissue typing of family members and other donor procurement costs.

What's Not Covered. These plans do not cover:

- Donor costs for a transplant not covered under these plans, or for a recipient who is not a plan participant (however, complications and unforeseen effects from a plan participant's organ or bone marrow donation are covered as any other illness)
- Donor costs for which benefits are available under other group coverage
- Non-human or mechanical organs, unless deemed non-experimental and non-investigational by these plans
- Organ or bone marrow search or selection costs (including registry charges), unless described as covered.

► Urgent Care

These plans cover treatment for conditions that are not considered a medical emergency but may need immediate medical attention. Examples of urgent conditions include:

- Ear infections
- High fevers
- Minor burns.

If you need urgent care during office hours, call your physician's office for assistance. After office hours, call your physician's office and contact the on-call physician. Depending on your situation, the physician may provide instructions over the phone, ask you to come in to the office or advise you to go to the nearest emergency room.

If you see a network provider for urgent care, you receive network-level benefits; if you see a non-network provider, you receive non-network benefits. However, if you need emergency care, it is covered at network levels whether you see a network or non-network provider.

Expenses Not Covered

Medical Services. In addition to the exclusions or limits described in other sections of this booklet, the KingCare plans do not cover:

- Benefits that are covered by the following agencies or programs (or benefits that would be covered by these agencies or programs if the KingCare plans didn't cover them), except as required by law:
  - Any federal, state or government program (except for facilities in Aetna's list of network providers)
  - Government facilities outside the service area
  - Medicare
  - Workers compensation or state industrial coverage
- Benefits payable under any automobile, medical personal injury protection, homeowner, commercial premises coverage or similar contract (reimbursement to Aetna is made without reduction for any attorney's fees, except as specified in the contract)
- Biofeedback
- Charges that exceed UCR amounts
- Charges that, without these plans, would not have to be paid, such as services performed by a family member
- Chronic mental health condition treatment (inpatient or outpatient) such as for mental retardation, mental deficiency or forms of senile deterioration resulting from service in the armed forces, declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism
- Cosmetic surgery except:
  - For all stages of reconstruction on the non-diseased breast to make it equal in size to the reconstructed diseased breast following mastectomy

  - For reconstructive breast surgery on the diseased breast necessary because of a mastectomy
  - For congenital anomalies of a dependent child
  - When related to a disfiguring injury
- Court-ordered services or programs not judged medically necessary by the plans
- Custodial care solely to assist with normal daily activities (such as dressing, feeding and ambulation) or any other treatment that does not require the services of a registered nurse or licensed practical nurse
- Dental charges, except for natural teeth injured in an accident while covered by the plans (this treatment must be within one year of the accident)
- Dependent child maternity treatment, services or drugs
- Exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, license, certification, registration, sports or recreational activities
- Experimental or investigational services, supplies or settings
- Fertility services such as reversal of voluntary sterilization, voluntary removal of birth control devices implanted under the skin (for example, Norplant), any fees relating to donor sperm, menotropins (such as Pergonal) or related drug therapy, or surrogate parenting fees
- Foot care considered routine such as hygienic care, treatment for flat feet, removal of corns or calluses, corrective orthopedic shoes, arch supports or orthotics unless needed for diabetes or other covered conditions
- Hospitalization solely for diagnostic purposes when not medically necessary
- Injuries sustained:
  - By an intentional overdose of a legal prescription, over-the-counter drug, illegal drug or other chemical substance
  - From suicide or attempted suicide (unless the patient was being treated by a mental health professional immediately before or after attempt)
  - While engaged in any activity that results in a felony conviction
  - While performing any acts of violence or physical force
- Jaw abnormalities, malocclusions or any related appliances
- Non-approved drugs and substances (those the FDA has not approved for general use and labeled "Caution – limited by federal law to investigational use")
- Not medically necessary services and supplies to treat illness or injury, except for newborns and unless otherwise specified
- Obesity surgery or other procedures, treatment or services such as gastric intestinal bypass surgery (unless preauthorized)
- Schools or other non-medical facilities that primarily provide educational, vocational, custodial and/or rehabilitative support, training or similar services
- Services of a provider related to you by blood, marriage, adoption or legal dependency
- Sexual dysfunction or transsexualism surgery, treatment or prescriptions
- Third-party required treatment or evaluations such as those for school, employment, flight clearance, summer camp, insurance or court
- Vision tests unless due to illness or injury; these plans also do not cover:
  - Contact lenses (except for cataract surgery)
  - Eyeglasses or their fittings
  - Orthoptics
  - Radial keratotomy or similar surgery for treating myopia
  - Visual analysis, therapy or training.

Prescription Drug Services. In addition to the exclusions or limits described in other sections of this booklet, the plans do not cover:

- Charges that exceed the amounts AdvancePCS pays its network pharmacies
- Drugs for dependent child's maternity
- Infertility drugs, including Viagra (unless preauthorized)
- Non-approved drugs and substances (those the FDA has not approved for general use and labeled "Caution – limited by federal law to investigational use")
- Sexual dysfunction or transsexualism drugs.

Coordination of Benefits

► Coordination of Benefits between Plans

King County plans coordinate benefits under a non-duplication policy between primary and secondary plans. That means if a plan is primary, it pays first; if it is secondary, it pays only the difference between what the primary plan paid and what the secondary plan would have paid if it was primary.

If you and a family member both have your own health coverage (medical, dental and vision) and you cover each other as dependents under your plans, your own plans are primary for each of you and secondary for each other.

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine what plan is primary for dependent children covered under two parents ("parents" in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- If the parents are divorced or legally separated, these rules apply:
  - If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first
  - If there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody
  - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer these coordination of benefit procedures.

► Coordination of Benefits with Medicare

If you keep working for the county after age 65 you may:

- Continue your medical coverage under a county plan and integrate the county plan with Medicare (the county plan would be primary).
- Discontinue your county medical coverage and enroll in Medicare. If you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months (see "COBRA" in the Important Facts booklet).

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan covering a person as an active employee or family member of an active employee. Medicare is primary in most other circumstances.

If you have any questions about how your coverage coordinates with Medicare, contact your medical plan (see the Resource Directory booklet).

Filing a Claim

► How to File a Medical Claim with Aetna

If you receive care from Aetna network providers, they submit claims for you.

If you receive care from a non-network medical service provider, you pay the provider in full, and it's your responsibility to submit a claim to Aetna or have the provider submit one for you. Claim forms are available from the plans (see Resource Directory booklet).

When submitting any claim, you need to include your itemized bill. It should show:
- Patient's name
- Provider's tax ID number
- Diagnosis or ICD-9 code
- Date of service
- Itemized charges from the provider for the services received.

You also need to provide:
- Your name (if you were not the patient)
- Your Social Security number (or unique identifier number if assigned one by your plan)
- Group number 725069.

For prompt payment, submit all claims as soon as possible. Generally, your plan will not pay a claim submitted more than 12 months after the date of service. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

► How a Claim is Reviewed by Aetna

Aetna reviews your claim and notifies you or your provider in writing within the following timeframes:
- **Within 72 hours for urgent claims.** Urgent claims are those where your provider believes a delay in treatment could seriously jeopardize your life, health or ability to regain maximum function, or cause severe pain that can't be controlled adequately without the care being considered. Urgent claims can be submitted by phone or fax. You will be notified of the claim review decision by phone, followed by a written notice.
- **Within 15 days for pre-service claims (within 30 days if an extension is filed).** Pre-service claims are those where your plan requires you to obtain approval of the benefit before receiving the care. The plan may ask for a one-time extension of 15 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.
- **Within 24 hours for concurrent claims.** Concurrent claims are those for continuation of services previously approved by the claim administrator as an ongoing course of treatment or to be provided over a certain period.
- **Within 30 days for post-service claims (within 60 days if an extension is filed).** Post-service claims are claims that aren't urgent, pre-service or concurrent. Your plan may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claim administrator reviews your claim, applying plan provisions and their discretion in interpreting plan provisions, and then notifies you of the decision within the timeframes listed above.

► If the Claim is Approved by Aetna

If the claim is approved and there is no indication the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

Reimbursement to non-network providers is for the maximum allowable fees paid by your plan. If a non-network provider charges more than what AdvancePCS pays its network pharmacies, you or your covered family members pay the extra amount.

► If the Claim Is Denied by Aetna

If the claim is denied, you are notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that the carrier reviewed in making the determination.

► How to File Prescription Drug Claims with AdvancePCS

The majority of prescription claims are processed on line at the time of dispensing from the network pharmacy, so a paper claim is not required.

If you fill a prescription through a non-network pharmacy, you pay the pharmacy in full, and it's your responsibility to submit a claim form to AdvancePCS. Claim forms are available from the plan (see Resource Directory booklet).

When submitting a pharmacy claim, you need to include a completed claim form, along with the original prescription receipt, containing the following information:

- Patient's name
- NABP number (if listed on label)
- Prescription number
- Date filled
- Dollar amount
- Quantity
- Days supply
- NDC
- For compounds, the ingredients and the NDC# of the highest priced legend drug used (listed on label).

After your claim is processed, you receive written notice describing the approval (amount submitted, amount covered/allowed and amount of reimbursement) or the reason for denial. Payment for covered prescriptions is made directly to you. Reimbursement typically takes about 14 days.

If a non-network provider charges more than the rates AdvancePCS pays its network providers, you pay the extra amount.

Appealing Denied Claims

► Claims Denied for Reasons Other Than Eligibility

If a properly filed claim is denied in whole or in part, the Aetna or AdvancePCS service representative notifies you and your provider with an explanation in writing. When a claim is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim is denied for eligibility reasons, follow the steps described in "Claims Denied Due to Eligibility."

If you or your representative disagrees with the claim denial, you may try to resolve any misunderstanding by calling the appropriate claim administrator (Aetna or AdvancePCS) and providing more information. If you'd rather communicate in writing or the issue isn't resolved with a call, you may file a written appeal.

You have 180 days after receiving a claim denial notice to file a written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

The claim administrator reviews the written appeal and notifies you or your representative of their decision within these timeframes:

- Within 72 hours for urgent appeals
- Within 14 days for pre-service appeals (within 30 days if an extension is filed)
- Within 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

The claim administrator reviews your appeal, applying plan provisions and their discretion in interpreting plan provisions, then notifies you of the decision within the timeframes listed above. If the claim appeal is denied, you

are notified in writing of reasons for the denial. The claim administrator has sole discretionary authority to determine benefit payment under the plans; their decisions are final and binding.

If the appeal is denied, legal remedies may be pursued, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on or you forfeit your right to legal action.

You must file an appeal within the given timeframe or you may forfeit your right to further consideration of your claim.

► Claims Denied Due to Eligibility

If you have eligibility questions or believe you've had a claim denied because your plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of the section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or your plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these timeframes:

- Within 72 hours for urgent appeals (call 206-684-1556 to file an urgent appeal)
- Within 14 days for pre-service appeals (within 30 days if an extension is filed)
- Within 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under these plans; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Release of Medical Information

As a condition of receiving benefits under these plans, you and your family members authorize:

- Any provider to disclose to the plans any requested medical information
- The plans to examine your medical records at the offices of any provider
- The plans to release to or obtain from any person or organization any information necessary to administer your benefits
- The plans to examine records that would verify eligibility.

The plans will keep this information confidential whenever possible, but under certain necessary circumstances, it may be disclosed without specific authorization.

Certificate of Coverage

When your coverage under one of these plans ends, you automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under one of the KingCare plans.

Converting Your Coverage

If you're no longer eligible for the KingCare medical coverage described in this booklet, you may transfer your coverage to an Aetna insured conversion plan without evidence of insurability. The plan you convert to will differ from the benefits described in this booklet; if it includes a prescription drug benefit, claims will be processed by Aetna, not AdvancePCS (you may not transfer your AdvancePCS coverage to an insured conversion plan).

If you transfer your coverage to an Aetna insured conversion plan, you must pay premiums, which may be higher than the amount you currently pay (if any) for these benefits.

You will not be able to convert to the individual policy if you are eligible for any other medical coverage under any other group plan (including Medicare).

To apply for a conversion plan, you must complete and return an application form to Aetna within 31 days after this medical coverage terminates (see Resource Directory booklet). You will not receive the application or information about conversion plan coverage unless you request it from Aetna.

Extension of Coverage

If you or your covered family members are hospitalized when your medical coverage terminates, the plans continue to provide coverage until discharge. Coverage ends on the date of discharge or when you or your covered family member reaches the plan maximums, whichever comes first.

If you or your covered family member is totally disabled, and your coverage ends for any reason except plan termination, medical coverage for only the disabling condition may be extended for 12 months at no cost to you. The disabled person may choose either this medical extension or COBRA coverage, but electing the extension means they forfeit the right to elect COBRA coverage and convert to an individual policy. Other family members may be able to elect coverage through COBRA (see "Continuation of Health Benefits If You Become Disabled" in the Important Facts booklet).

Payment of Medical Benefits

These medical and prescription drug benefits are funded by King County, meaning these are "self-funded" plans where King County is financially responsible for claim payments and other costs.

Booklet 3

Group Health Medical

Although these benefit descriptions include certain key features and brief summaries of King County regular employee and part-time Local 587 benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

Table of Contents: Group Health Medical

Overview

► Highlights of Coverage under Group Health

Here are a few highlights of your coverage under the Group Health plan:
- You do not pay an annual deductible under this plan
- You pay copays for office visits and prescription drugs
- You must select a Group Health primary care physician (PCP)
- Your PCP can provide and coordinate all services through the Group Health network unless you have an emergency or your PCP refers you outside the network
- You may self-refer to Group Health staff specialists directly, without going through your PCP
- Network benefits are generally paid at 100% after the copays.

► Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:
- Who's eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

When you receive medical care, you pay:
- Required copays at the time of the service
- Coinsurance amounts not covered by the plan
- Expenses for services or supplies not covered by the plan.

A billing fee may be charged by Group Health if copays or bills reflecting expenses not covered by the plan are not paid within 30 days of the billing date.

See "Plan Features" in this booklet for details on deductibles, copays and coinsurance amounts; also see the latest new hire guides and open enrollment materials for details about monthly premiums you must pay (if any) for coverage.

Preexisting Condition Limit

This plan does not have a preexisting condition limit. However, there is a waiting period for transplants and growth hormones (see "Transplants" and "Growth Hormones" in the "Covered Expenses under Group Health" section of this booklet).

If you end employment with King County, please refer to "Certificate of Coverage" in this booklet for information on how your participation in this plan can be credited against another plan with a preexisting condition limit.

How the Plan Works

► Plan Features

The following table identifies some plan features, including your out-of-pocket maximum and how benefits are determined for most covered expenses. The sections following the table contain additional details.

Plan Feature	Group Health
Provider choice	You choose a Group Health PCP who provides and coordinates most services through the Group Health network; you may also self-refer to Group Health staff specialists; no non-network coverage unless indicated
Annual deductible	None
Copays	See "Summary of Covered Expenses" for amounts
After the copays, the plan pays most covered services at this level …	100% network
Until you reach your annual out-of-pocket maximum…	$1,000/person, $2,000/family for network care and limited emergency/out-of-area non-network care
Then, most benefits are paid for the rest of the calendar year at …	100% network
Lifetime maximum	No limit

► Network Providers

Network providers may be either staff members of Group Health or contracted professionals. All providers who make up the network are carefully screened by Group Health. Doctors and other health care professionals must complete a detailed application to be considered for the network. The application covers education, status of board certification, malpractice and state sanction histories. For a list of network providers, contact Group Health (see the Resource Directory booklet).

► Out-of-Area Coverage

This plan does not provide out-of-area benefits except for emergency care. If you or a family member is away from home you may be able to access urgent or emergency care at network benefit levels in HMOs associated with Group Health. You or your family member can use the Kaiser Permanente network for urgent or emergency care while traveling. For out-of-area emergency care, contact 1-888-457-9516 or 1-888-901-4636.

► Selecting a Primary Care Physician

Your PCP is your personal doctor and can act as the coordinator of all your medical care. PCPs can be family or general practitioners, internists or pediatricians. If you need a specialist, your PCP can arrange it.

You are strongly encouraged to select a PCP from the Group Health network provider directory when you enroll. Each family member may have a different PCP. The provider directory is updated periodically; for current information about providers, contact Group Health (see Resource Directory booklet).

Continuity of your care is important, and easier to achieve if you establish a long-term relationship with your PCP. However, if you find it necessary to change your PCP, call Group Health.

► Specialists

Your PCP can provide or coordinate your medical care, including specialists. In most cases, your doctor will refer you to a network specialist. Or, if you wish, you may make appointments directly with any Group Health staff

specialist without a referral from your PCP. However, referrals are required to see contracted specialists. (You can tell the difference between a Group Health staff specialist and a contracted specialist because Group Health staff specialists practice in Group Health facilities.)

When you're referred to any network specialist (staff specialist or contracted specialist), be sure to get a copy of the referral form from your PCP and take it to the specialist. To allow your PCP to coordinate your care most effectively, check back with him or her after a specific time or number of specialist visits. If you have a complex or chronic medical condition, you may obtain a standing specialist referral.

If you see a non-network provider without a referral, benefits may not be payable.

► Annual Out-of-Pocket Maximum

The out-of-pocket maximum is generally the most you pay toward copays each plan year. This means once you reach your out-of-pocket maximum, the Group Health plan pays 100% of most covered expenses for the rest of the calendar year.

The following do not apply to the out-of-pocket maximum:
- Eyeglasses and contact lenses
- Health education
- Hearing aids
- Inpatient mental health
- Outpatient mental health
- Prescription drugs
- Residential day treatment
- Services and supplies not covered by the plan.

► Accessing Care

Generally, to receive benefits:
- You make an appointment with a network provider
- You pay a $20 office visit copay at the time you receive health care services
- After the copay, the plan pays 100% for most covered services and handles all forms and paperwork.

You may receive benefits when you see non-network providers in the following situations only:
- Emergency care
- If your network provider refers you to a non-network provider.

► Second Opinions

You may request a second opinion regarding a medical diagnosis or treatment plan from a network provider.

Covered Expenses under Group Health

► Summary of Covered Expenses

The table beginning on the following page summarizes covered services and supplies under this plan (only medically necessary services and supplies are covered) and identifies related coinsurance, copays, maximums and limits. Also see the sections after the table as well as "Expenses Not Covered."

Covered Expenses	Group Health
Alternative care	Self-referrals to a network provider are covered up to 5 visits/medical diagnosis/calendar year for acupuncture and up to 2 visits/medical diagnosis/calendar year for naturopathy; all other alternative care may require PCP referral All services are subject to the $20 copay/visit
Ambulance services	80%
Chemical dependency treatment	100% after $200 copay/admission for inpatient care 100% after $20 copay/visit for outpatient care $11,285 maximum/24 consecutive months (maximum subject to annual adjustment)
Chiropractic care and manipulative therapy (like all services, must be medically necessary)	100% after $20 copay/visit
Circumcision	100% after $20 copay/visit
Devices, equipment and supplies	80% if authorized in advance by a network provider as medically necessary
Diabetes care training	100% after $20 copay/visit
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs
Emergency room care	100% after $75 copay/visit to network facility ($75 copay is waived but $200 copay/admission for hospital care applies if admitted) 100% after $125 copay/visit to non-network facility ($125 copay applies in addition to $200 copay/admission for hospital care if admitted) Non-emergency care not covered
Family planning	100% after $20 copay/visit (infertility treatment not covered)
Growth hormones	Covered under prescription drugs if medical coverage has been continuous for more than 12 months under this plan
Hearing aids	100% up to $300/ear in 36 months
Home health care	100%
Hospice care	100% when preauthorized
Hospital care	100% after $200 copay/admission
Infertility treatment	Not covered
Inpatient care alternatives	100%
Lab, x-ray and other diagnostic testing	100%
Massage therapy (like all services, must be medically necessary)	100% after $20 copay/visit with PCP referral
Maternity care	100% for delivery and related hospital care after $200 copay/admission 100% after $20 copay/visit for prenatal and postpartum care
Mental health care	80% up to 12 days/year for inpatient 100% after $20 copay/individual, family or couple visit or $10 copay/group session for outpatient Up to 20 outpatient visits/year

Covered Expenses	Group Health
Neurodevelopmental therapy for covered family members age 6 and under	100% for inpatient services after $200 copay/admission up to 60 days/condition/year 100% after $20 copay/visit for outpatient up to 60 visits/year for each condition
Out-of-area coverage for your children away at school	Reciprocal benefits available through Kaiser Permanente and affiliated HMOs; only emergency services covered in all other areas
Physician and other medical/surgical services	100% after $20 copay/visit
Phenylketonuria (PKU) formula	100%
Prescription drugs – up to 30-day supply through network pharmacies	100% after $10 copay for generic 100% after $20 copay for preferred brand 100% after $30 copay for non-preferred brand No reimbursement for prescriptions filled at non-network pharmacies
Prescription drugs – up to 90-day supply through mail order	100% after $20 copay for generic 100% after $40 copay for preferred brand 100% after $60 copay for non-preferred brand
Preventive care (check-ups, immunizations, routine health and hearing exams, etc.)	100% (according to well-child/adult preventive care schedule) Immunizations for travel not covered
Radiation therapy, chemotherapy and respiratory therapy	100% after $20 copay/visit
Reconstructive services (includes benefits for mastectomy-related services **–** reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema; call plan for more information)	100% depending on services provided; copays may apply (including $200 copay/admission if hospital care required)
Rehabilitative services	100% for inpatient services after $200 copay/admission up to 60 days/condition/calendar year 100% after $20 copay/visit for outpatient services Up to 60 visits/year/condition
Skilled nursing facility	100% up to 60 days/calendar year at a Group Health-approved nursing facility
Smoking cessation	100% for 1 Group Health network provider program/year 100% or the amount of a prescription drug copay (whichever is less) for nicotine replacement therapy up to 30-day supply
Temporomandibular joint (TMJ) disorders	100% for inpatient care after $200 copay/admission 100% after $20 copay/visit for outpatient care Up to $1,000/year and a $5,000 lifetime maximum
Transplants	100% after applicable copays Medical coverage must have been continuous for more than 12 months under this plan – whether preexisting or an emergency
Urgent care (ear infections, high fevers, minor burns, etc.)	100% after $20 copay/visit
Vision exams	100% after $20 copay/visit up to 1 exam/person in 12 consecutive months (Group Health provides exams only; your separate Vision Service Plan provides eye exams, prescription lenses and frames)

► Alternative Care

Covered services include:
- Acupuncture; covered up to five visits per medical diagnosis in a calendar year
- Chiropractic; must be medically necessary; covered up to 10 visits per year
- Home births; you may see any Group Health network midwife for covered prenatal and home birth services
- Massage therapy; must be medically necessary and part of a formal rehabilitation program
- Naturopathy; covered up to two visits per medical diagnosis in a calendar year.

You can self-refer for acupuncture, chiropractic and naturopathy care but network provider referral is required for home births and massage therapy.

► Ambulance Services

Services of an ambulance company are covered if:
- Ordered or approved by your PCP
- Other transportation would endanger your health, and
- The transportation is not for personal or convenience reasons.

► Chemical Dependency Treatment

Your PCP can arrange chemical dependency services, or for outpatient care, you may call Group Health Behavioral Health at 1-888-287-2680.

Treatment may include the following inpatient or outpatient services:
- Covered prescription drugs and medicines
- Diagnostic evaluation and education
- Organized individual and group counseling.

Detoxification services are covered as any other medical condition and are not subject to the chemical dependency limit. Chemical dependency means a physiological and/or psychological dependency on a controlled substance and/or alcohol, where your health is substantially impaired or endangered, or your ability to function socially or to work is substantially disrupted.

► Chiropractic Care and Manipulative Therapy

Medically necessary manipulative therapy of the spine and extremities is covered. You do not need a referral from your PCP before you see a network chiropractor or osteopath. Associated x-rays are covered when provided at a Group Health radiology facility.

► Devices, Equipment and Supplies

Covered equipment and appliances include:
- Nasal CPAP devices
- Orthopedic appliances
- Post-mastectomy bras
- Prosthetic devices.

Durable medical equipment is covered if:
- Designed for prolonged use
- It has a specific therapeutic purpose in treating your illness or injury
- Prescribed by your PCP and part of the Group Health formulary, and
- Primarily and customarily used only for medical purposes.

Covered items include:
- Artificial limbs or eyes (including implant lenses prescribed by a network provider and required as a result of cataract surgery or to replace a missing portion of the eye)
- Casts, splints, crutches, trusses or braces
- Diabetic equipment for home testing and insulin administration not covered under the prescription benefit (excluding batteries)
- External breast prosthesis (covered at 100%) and bra following mastectomy (covered at 50%); one external breast prosthesis is available every two years (per diseased breast), and two post-mastectomy bras are available every six months (up to four in any consecutive 12 months)
- Non-prosthetic orthopedic appliances attached to an impaired body segment; these appliances must protect the body segment or aid in restoring or improving its function
- Ostomy supplies
- Oxygen and equipment for its administration
- Purchase of nasal CPAP devices and initial purchase of associated supplies (you must rent the device for one month before purchase to establish compliance)
- Rental or purchase (decided by the plan) of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price).

► Diabetes Care Training and Supplies

Diabetes care training includes diet counseling, enrollment in diabetes registry and a wide variety of education materials; these are covered under the prescription drug benefit.

Covered supplies include:
- Blood glucose monitoring reagents
- Diabetic monitoring equipment
- External insulin pumps
- Insulin syringes
- Lancets
- Urine testing reagents.

► Emergency Care

Emergency care treats medical conditions that threaten loss of life or limb, or may cause serious harm to the patient's health if not treated immediately. You do not need a referral from your PCP before you receive emergency room care.

Examples of conditions that might require emergency care include:
- An apparent heart attack (chest pain, sweating, nausea)
- Bleeding that will not stop
- Convulsions
- Major burns
- Severe breathing problems
- Unconsciousness or confusion, especially after a head injury.

If you need emergency care, follow these steps:
- Dial 911 or go to the nearest hospital emergency room immediately. In cases when you can choose an emergency location, go to the Eastside Hospital in Redmond; this will allow us to coordinate your care efficiently and perhaps reduce your expenses.
- When you arrive, show your Group Health ID card.
- If you're admitted to a non-network facility, you must call 1-888-457-9516 within 24 hours; otherwise you may be responsible for all costs incurred before you call. If you are unable to call, have a friend, relative or hospital staff person call for you. The plan's phone number also is printed on the back of your ID card.

- If you are admitted to a health care facility, you must notify Group Health within 24 hours. You may be required to transfer your care to a network provider and/or Group Health facility. If you refuse to transfer to a Group Health facility, all further costs incurred during the hospitalization are your responsibility.

In general, follow-up care that is a direct result of the emergency must be received through Group Health. Non-emergency use of an emergency facility is not covered.

► Family Planning

Covered family planning expenses include:
- Family planning counseling
- Services to insert intrauterine birth control devices (IUDs)
- Sterilization procedures
- Voluntary termination of pregnancy.

The plan does not cover:
- Infertility treatment, sterility or sexual dysfunction treatment or diagnostic testing
- Procedures to reverse voluntary sterilization.

Birth control drugs are covered under the prescription drug benefit.

► Growth Hormones

Growth hormones are covered, subject to the prescription drug copay. You or your family member will not be eligible for any growth hormone benefits until the first day of the 13th month of continuous coverage under this plan (unless continually covered under this plan from birth).

► Hearing Aids

Hearing aids (including fitting, rental and repair) are covered at the level shown in the "Summary of Covered Expenses" in this booklet.

► Home Health Care

Home health care is covered if the patient is unable to leave home due to health problems or illness and the care is necessary because of a medically predictable, recurring need. Unwillingness to travel and/or arrange for transportation does not constitute an inability to leave home. If you have an approved plan of treatment and referral from a network provider, covered expenses include:
- Medical social worker and limited home health aide services
- Nursing care
- Occupational therapy
- Physical therapy
- Respiratory therapy
- Restorative speech therapy.

The following services are not covered:
- Any care provided by a member of the patient's family
- Any other services rendered in the home that are not specifically listed as covered
- Custodial care or maintenance care
- Housekeeping or meal services
- Private duty or continuous care in the patient's home.

► Hospice Care

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. The team may include a physician, nurse, medical social worker, physical, speech, occupational or respiratory therapist or home health aide under the supervision of a registered nurse.

Hospice services are covered if:
- A network provider determines the patient's illness is terminal, with life expectancy of six months or less, and can be appropriately managed in the home or hospice facility
- The patient has chosen comforting and supportive services rather than treatment aimed at curing their terminal illness
- The patient has elected in writing to receive hospice care through the Group Health-approved hospice program, and
- The patient has a primary care person who will be responsible for the patient's home care.

One period of continuous home care hospice service is covered. A continuous home care period is skilled nursing care provided in the home 24 hours a day during a period of crisis to maintain a terminally ill patient at home. A network provider must determine the patient would otherwise require hospitalization.

Continuous respite care may be covered for up to five days per occurrence of hospice care. Respite care must be given in the most appropriate setting as determined by your network provider.

The following services are not covered:
- Any services provided by members of the patient's family
- Custodial care or maintenance care
- Financial or legal counseling (examples are estate planning or the drafting of a will)
- Funeral arrangements
- Homemaker, caretaker or other services not solely related to the patient, such as:
- House cleaning or upkeep
- Meal services
- Sitter or companion services for either the plan participant who is ill or for other family members
- Transportation.

► Hospital Care

The following hospital care expenses are covered under this plan:
- Drugs listed in the plan formulary
- Hospital services
- Room and board
- Special duty nursing.

► Infertility

Infertility treatment is not covered under this plan.

► Injury to Teeth

Injuries to teeth are not covered under this plan.

► Inpatient Care Alternatives

See "Skilled Nursing Facility" and "Home Health Care" sections.

► Lab, X-ray and Other Diagnostic Testing

This plan covers diagnostic x-ray, nuclear medicine, ultrasound and laboratory services. See "Preventive Care" in this booklet for more information on routine diagnostic testing (for example, mammograms).

► Maternity Care

Maternity care is covered if provided by a:
- Physician
- Provider licensed as a midwife by Washington State.

Covered maternity care includes:
- Complications of pregnancy or delivery
- Hospitalization and delivery, including home births and certain birthing centers for low-risk pregnancies
- Postpartum care
- Pregnancy care
- Related genetic counseling when medically necessary for prenatal diagnosis of an unborn child's congenital disorders
- Screening and diagnostic procedures during pregnancy.

The plan does not cover home pregnancy tests.

Group health plans and health insurance issuers offering group coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

► Mental Health Care

Inpatient and outpatient mental health services are covered. These services place priority on restoring social and occupational functioning; they include:
- Consultations
- Crisis intervention
- Evaluation
- Intermittent care
- Managed psychotherapy
- Psychological testing.

Your PCP can arrange for mental health services or you can contact Group Health Behavioral Health directly by calling 1-888-287-2680. (Counseling and referral services are also available through King County's Making Life Easier Program by calling 1-888-874-7290.)

The following mental health services are not covered:
- Custodial care
- Day treatment
- Specialty programs for mental health therapy not provided by Group Health
- Treatment of sexual disorders.

► Neurodevelopmental Therapy

The plan covers neurodevelopmental therapy for covered family members age six and younger, including:
- Hospital care

- Maintenance of the patient when his or her condition would significantly worsen without such services
- Occupational, speech and physical therapy (if ordered and periodically reviewed by a physician)
- Physicians' services
- Services to restore and improve function.

The plan does not cover:
- Implementation of home maintenance programs
- Physical, occupational or speech therapy services when available through government programs
- Programs for the treatment of learning problems
- Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the patient's level of functioning.

► Newborn Care

The plan covers newborns under the mother's coverage for the first three weeks, as required by Washington State law. To continue the newborn's coverage after three weeks, the newborn must be eligible and enrolled by the deadline as described in the Important Facts booklet.

► Physician and Other Medical/Surgical Services

Several other medical and surgical services are covered by this plan, including:
- Blood and blood derivatives and their administration
- Diabetic supplies (insulin syringes, lancets, urine-testing reagents and blood-glucose monitoring reagents)
- Nonexperimental implants limited to cardiac devices, artificial joints and intraocular lenses
- Outpatient diagnostic radiology and lab services
- Outpatient radiation therapy and chemotherapy
- Outpatient surgical services
- Outpatient total parenteral nutrition therapy
- Services of a podiatrist (routine foot care not covered)
- Services performed by a network provider or oral surgeon (reduction of a fracture or dislocation of the jaw or facial bones, excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof or floor of the mouth, incision of salivary glands and ducts; accidental injury to teeth not covered)
- Treatment of growth disorders by growth hormones.

► PKU Formula

The plan covers the medical dietary formula that treats phenylketonuria (PKU).

► Prescription Drugs

Benefits are provided for legend drugs (prescription drugs with an 11-digit code assigned by the labeler or distributor under FSA regulations) and other covered items (including insulin, injectables and contraceptive drugs and devices) when you use a network pharmacy or mail order, including off-label use of FDA-approved drugs. To be covered, prescriptions must be:
- Filled through a network pharmacy or mail order
- Prescribed by a network provider for covered conditions.

The plan does not cover:
- Dental prescriptions
- Drugs for cosmetic uses
- Drugs for treatment of sexual dysfunction
- Drugs not approved by the FDA and in general use as of March 1 of the previous year
- Over-the-counter drugs.

To fill your prescription through a network pharmacy, show the pharmacist your Group Health card. For mail order prescriptions, your provider first prescribes a 30-day "trial" supply and you fill it through a network pharmacy. If the trial supply is effective, you order a 90-day supply by contacting the mail order service through the Group Health website (see Resource Directory booklet) or calling 1-800-245-7979. The service mails your prescription to your home.

If you need a refill, check the label on the prescription container; some may be refilled without consulting your provider. The number of refills is indicated on the label. If you need your provider's approval to refill your medication, call your pharmacy or the mail order service at least two weeks before you run out of medication. The pharmacy/mail order service will need time to order your medicine and contact your provider for approval.

You may receive up to a 30-day supply per copay from a network pharmacy and up to a 90-day supply per copay from the network mail order service (see "Summary of Covered Expenses" for copay amounts). Generic drugs are used whenever available. Brand-name drugs are used if there is no generic equivalent. If available at the network pharmacy, you may buy specific brand-name drugs by paying the higher copay.

► Preventive Care

The plan covers the following preventive care:
- Most immunizations and vaccinations for adults and children (except immunizations for travel)
- Routine hearing exams (once in 12 consecutive months)
- Routine mammograms (age and risk factor determine frequency)
- Routine physicals for adults and children (age and risk factor determine frequency)
- Routine vision exams (once in 12 consecutive months).

► Radiation Therapy, Chemotherapy and Respiratory Therapy

Covered expenses include radiation therapy, high-dose chemotherapy and stem cell support, and respiratory therapy services.

► Reconstructive Services

Reconstructive services are covered to correct a congenital disease/anomaly or a medical condition (following an injury or incidental to surgery) that had a major effect on the patient's appearance (the reconstructive services must, in the opinion of a network provider, be reasonably expected to correct the condition).

Covered individuals receiving benefits for a mastectomy who elect breast reconstruction in connection with the mastectomy, as determined in consultation with the patient and attending physician, have these benefits:
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas
- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the healthy breast to produce a symmetrical appearance.

These reconstructive benefits are subject to the same copays and coinsurance provisions as other medical and surgical benefits.

► Rehabilitative Services

Covered inpatient and outpatient rehabilitative services are limited to physical, occupational and speech therapy to restore function after illness, injury or surgery.

The plan does not cover:
- Implementation of home maintenance programs
- Physical, occupational or speech therapy services when available through government programs
- Programs for the treatment of learning problems

- Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the patient's level of functioning.

Rehabilitative services are covered only when the plan determines they are expected to result in significant, measurable improvement within 60 days. Rehabilitative services for chronic conditions are not covered.

► Skilled Nursing Facility

Skilled nursing facility services are covered, when referred by a network provider, to a maximum of 60 days each calendar year.

► Smoking Cessation

You do not need a PCP referral before you see a network provider for these services.

Services related to tobacco cessation are covered, limited to:
- One course of nicotine replacement therapy a year if you're actively participating in the Group Health Free and Clear Program
- Educational materials
- Participation in one program a year from a network provider.

► TMJ Disorders

Medical and surgical services and related hospitalizations to treat temporomandibular joint (TMJ) disorders are covered when medically necessary, subject to the limits in the "Summary of Covered Expenses." Orthognathic (jaw) surgery, radiology services and TMJ specialist services, including the fitting and adjustment of splints, also are covered. TMJ appliances are covered under the orthopedic appliances benefit (see "Devices, Equipment and Supplies").

The following services, including related hospitalizations, are not covered by the plan regardless of origin or cause:
- All dental services (except as noted above), including orthodontic therapy
- Orthognathic (jaw) surgery in the absence of a TMJ diagnosis
- Treatment for cosmetic purposes.

Additional benefits are available through the dental plan (see Washington Dental Service booklet).

► Transplants

You or your family member will not be eligible for any organ transplant benefits until the first day of the 13th month of continuous coverage under this Group Health plan (unless continuously covered under this plan since birth).

The following transplants are covered:
- Bone marrow
- Cornea
- Heart
- Heart-lung
- Kidney
- Liver
- Lung (single or double)
- Pancreas/kidney (simultaneous).

Transplant services must be received at a facility designated by Group Health and are limited to:
- Evaluation testing to determine recipient candidacy

- Follow-up services for specialty visits, rehospitalization and maintenance medications
- Transplantation (limited to costs for surgery and hospitalization related to the transplant, as well as medications).

The plan covers the following donor expenses for a covered organ recipient:
- Excision fees
- Matching tests
- Procurement center fees
- Travel costs for a surgical team.

The plan does not cover:
- Donor costs reimbursable by the organ donor's insurance plan
- Living expenses
- Transportation expenses (except as listed above).

► Urgent Care

Sometimes you may need to see a physician for conditions that are not life threatening but need immediate medical attention. For example:
- Ear infections
- High fevers
- Minor burns.

For urgent care during office hours, call your PCP's office for assistance.

After office hours, call Group Health's Consulting Nurse Service at 1-800-297-6877. Depending on your situation, the consulting nurse may provide instructions over the phone for self-care, instruct you to make an appointment with your PCP for the next day or advise you to go to the nearest urgent care or emergency room.

Urgent care is covered the same as other care. Generally, urgent care involves an office visit and is paid at the level shown in the "Summary of Covered Expenses" in this booklet.

► Vision Exams

This plan covers routine vision exams only. Your separate Vision Service Plan provides eye exams, prescription lenses and frames (see Vision Service Plan booklet).

Expenses Not Covered

In addition to the exclusions or limits described in other sections of this booklet, the Group Health plan does not cover:
- Artificial or mechanical hearts
- Benefits covered by other insurance
- Cardiac or pulmonary rehabilitation
- Complications of non-covered surgical services
- Conditions resulting from service in the armed forces, declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism
- Convalescent or custodial care
- Corrective appliances or artificial aids including eyeglasses, contact lenses or services related to their fitting
- Cosmetic services, including treatment for complications of cosmetic surgery that is elective or not covered
- Court-ordered services or programs not judged medically necessary by the network provider
- Dental care, surgery, services and appliances, except as described in "Physician and Other Medical/Surgical Services" in this booklet
- Diabetic meals and some diabetes education materials

- Evaluations and surgical procedures to correct refractions not related to eye pathology
- Exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, license, certification, registration, sports, recreational or school activities
- Experimental or investigational treatment
- Gambling or other specialty treatment programs
- Hypnotherapy or any related services
- Medicine or injections for anticipated illness while traveling
- Methadone maintenance programs
- Obesity treatment, services or items, except for nutritional counseling by network staff
- Orthopedic shoes not attached to an orthopedic appliance or arch supports (including custom shoe inserts or their fitting except for therapeutic shoes and shoe inserts for severe diabetic foot disease)
- Orthoptic (eye training) therapy
- Over-the-counter drugs (medicines and devices not requiring a prescription)
- Personal comfort items, such as phones or television
- Physical exams, immunizations or evaluations primarily for the protection and convenience of third parties, including obtaining or continuing employment or insurance or government licensure
- Routine foot care
- Services or supplies resulting from the loss or willful damage to covered appliances, devices, supplies or materials provided by Group Health
- Services provided by government agencies, except as required by federal or state law
- Sterility, infertility or sexual dysfunction testing or treatment including Viagra, penile implants, vascular or artificial reconstruction, sterilization reversal or sex transformations
- Weight reduction programs
- Work-incurred injury, illness or condition treatment.

Coordination of Benefits

► Coordination of Benefits between Plans

If you and a family member both have your own Group Health coverage, your copays (and those of children you both cover) are waived. Otherwise, if you and a family member have coverage through different plans, the King County Group Health plan coordinates benefits under its standard coordination of benefits (COB) policy between primary and secondary plans. If Group Health is primary, it pays first; if it is secondary, it pays up to an amount equal to the difference between the total charge and what the primary plan paid (the exact amount depends on a calculation of COB savings to Group Health).

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine what plan is primary for dependent children covered under two parents with different medical plans ("parents" in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- If the parents are divorced or legally separated, these rules apply:
  - If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first.
  - If there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody.
  - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer these coordination of benefit procedures.

► Coordination of Benefits with Medicare

If you keep working for the county after age 65 you may:
- Continue your medical coverage under a county plan and integrate the county plan with Medicare (the county plan would be primary).
- Discontinue your county medical coverage and enroll in Medicare. If you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months (see "COBRA" in the Important Facts booklet).

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan covering a person as an active employee or family member of an active employee. Medicare is primary in most other circumstances.

If you have any questions about how your coverage coordinates with Medicare, contact your medical plan (see the Resource Directory booklet).

Filing a Claim

► What to Do

If you receive care from a network provider, the provider submits claims for you. If you receive emergency services from a non-network provider, you pay the provider in full, and it's your responsibility to submit a claim form to Group Health or have the provider submit one for you. Claim forms are available from Group Health (see the Resource Directory booklet).

When submitting any claim, you need to include your itemized bill. It should show:
- Patient's name
- Provider's tax ID number
- Diagnosis or ICD-9 code
- Date of service/supply
- Itemized charges from the provider for the services/supplies received.

You also need to provide:
- Your name (if you were not the patient)
- Your Social Security number (or unique identifier number if assigned one by your plan)
- Group number (shown on your Group Health ID card and available from Benefits and Retirement Operations).

For prompt payment, submit all claims as soon as possible. The plan will not pay a claim submitted more than 12 months after the date of service/supply. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

► How the Claim is Reviewed

Group Health will review your claim and notify you or your provider in writing within the following timeframes:
- **Within 72 hours for urgent claims.** Urgent claims are claims for services where your provider believes a delay in treatment could seriously jeopardize your life, health or ability to regain maximum function, or cause

severe pain that can't be controlled adequately without the care being considered. Urgent claims can be submitted by phone or fax (see the Resource Directory booklet). You will be notified of the claim review decision by phone with a written notice to follow.

- **Within 15 days for pre-service claims (within 30 days if an extension is filed).** Pre-service claims are those where the plan requires you to obtain approval of the benefit before receiving the care. The plan may ask for a one-time extension of 15 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.
- **Within 24 hours for concurrent claims.** Concurrent claims are those for continuation of services previously approved by the claim administrator as an ongoing course of treatment or to be provided over a certain period.
- **Within 30 days for post-service claims (within 60 days if an extension is filed).** Post-service claims are claims that aren't urgent, pre-service or concurrent. The plan may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claim administrator reviews your claim, applying plan provisions and their discretion in interpreting plan provisions, and then notifies you of the decision within the timeframes listed above.

► If the Claim is Approved

If the claim is approved and there is no indication the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

► If the Claim is Denied

If the claim is denied, you are notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that Group Health reviewed in making the determination.

Appealing Denied Claims

► Claims Denied for Reasons Other Than Eligibility

If a properly filed claim is denied in whole or in part, Group Health notifies you and your provider with an explanation in writing. When a claim is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim is denied for eligibility reasons, follow the steps described in the next section, "Claims Denied Due to Eligibility."

If you or your representative disagrees with the claim denial, you may try to resolve any misunderstanding by calling Group Health and providing more information. If you'd rather communicate in writing or the issue isn't resolved with a call, you may file a written appeal (see the Resource Directory booklet for contact information.)

You have 180 days after receiving a claim denial notice to file a written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

Group Health will review the written appeal and notify you or your representative of their decision within these timeframes:

- Within 72 hours for urgent appeals
- Within 14 days for pre-service appeals
- Within 30 days for post-service appeals
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

Your appeal is reviewed by someone different from the original decision makers and without deference to the initial decision. The appeal reviewer applies plan provisions and their discretion in interpreting plan provisions,

and then notifies you of the decision within the timeframes listed above. If the claim appeal is denied, you are notified in writing of reasons for the denial.

Group Health has sole discretionary authority to determine benefit payment under the plans; their decisions are final and binding.

If the appeal is denied, legal remedies may be pursued, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on or you forfeit your right to legal action.

► Claims Denied Due to Eligibility

If you have eligibility questions or believe you've had a claim denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of the section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these timeframes:

- Within 72 hours for urgent appeals (call 206-684-1556 to file an urgent appeal)
- Within 14 days for pre-service appeals (within 30 days if an extension is filed)
- Within 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Release of Medical Information

As a condition of receiving benefits under this plan, you and your family members authorize:

- Any provider to disclose to the plan any requested medical information
- The plan to examine your medical records at the offices of any provider
- The plan to release to or obtain from any person or organization any information necessary to administer your benefits
- The plan to examine records that would verify eligibility.

The plan will keep this information confidential whenever possible, but under certain necessary circumstances, it may be disclosed without specific authorization.

Certificate of Coverage

When your coverage under this plan ends, you automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan.

Converting Your Coverage

If you're no longer eligible for the medical coverage described in this booklet, you may transfer your coverage to an insured conversion plan. The plan you convert to will differ from the benefits described in this booklet. You must pay premiums, which may be higher than amounts you currently pay (if any) for these benefits.

You will not be able to convert to the individual policy if you are eligible for any other medical coverage under any other group plan (including Medicare).

To apply for a conversion plan, you must complete and return an application form to Group Health within 31 days after this medical coverage terminates. Evidence of insurability will not be required. You will not receive this application or information about conversion plan coverage unless you request it from Group Health.

Extension of Coverage

If this plan is canceled, Group Health will continue to cover any participants who are hospital inpatients on the cancellation date. Coverage ends on the date of discharge or when the participant reaches the plan maximums, whichever comes first.

Payment of Medical Benefits

The medical benefits offered by this plan are insured by Group Health, meaning this is not a self-funded plan. Group Health is financially responsible for claim payments and other costs.

Booklet 4

Washington Dental Service

Washington Dental Service

Although these benefit descriptions include certain key features and brief summaries of King County regular employee and part-time Local 587 benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

Table of Contents: Washington Dental Service Plan

Overview

Highlights of Coverage under Washington Dental Service (WDS)

Here are a few highlights of your dental benefits:
- You can use any dentist you wish (most dentists in Washington participate in the WDS plan)
- The plan pays benefits if you see a participating or non-participating dentist, but the benefits are generally higher (your out-of-pocket expenses are less) if you see a participating dentist
- Participating dentists file claims for you automatically.

Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:
- Who's eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

When you receive dental care, you pay:
- An annual deductible for applicable services (the annual deductible does not apply to diagnostic and preventive services, orthodontic services or accidental injuries)
- Coinsurance amounts not covered by the plan
- Amounts in excess of the allowable amounts (as determined by WDS) if you see a non-participating dentist
- Expenses for services or supplies not covered by the plan.

See "How the Plan Works" in this booklet (next page) for more information; also see the latest new hire guides and open enrollment materials for details about monthly premiums you must pay (if any) for the coverage.

How the Plan Works

Summary Table

The table on the following page summarizes covered services and supplies under this plan and identifies related deductibles, coinsurance and maximums (see "Covered Expenses under WDS" and "Expenses Not Covered" in this booklet for more details).

Washington Dental Service	
Annual deductible (doesn't apply to diagnostic and preventive services, orthodontic services or accidental injuries)	$25/person, $75/family
Annual maximum benefit (doesn't apply to orthodontic or TMJ services)	$2,000/person
Covered Expenses	**Plan Pays**
Diagnostic and preventive services • Exam and cleaning twice a calendar year • Periodontal cleaning and maintenance up to 4 times in a calendar year (under certain oral health conditions) • Complete x-rays every 3 years • Supplementary bitewing x-rays twice a calendar year	70% - 100% based on patient's incentive level (deductible doesn't apply)
Basic services • Crowns (stainless steel) • Extractions • Fillings • Periodontics • Root canals	70% - 100% based on patient's incentive level
Major services – restorative • Crowns • Onlays	70% - 85% based on patient's incentive level
Major services – prosthodontics • Dentures • Fixed bridges • Implants	70% (incentive levels do not apply)
Orthodontic services for adults and children	50% up to a $2,500 lifetime maximum (deductible and incentive levels do not apply; benefit doesn't apply to the annual maximum benefit) Not more than $1,250 will be paid during the initial stage of treatment; the remaining plan benefit is paid 7 months after the initial stage if the covered participant still meets eligibility requirements described in the Important Facts booklet
Night (occlusal) guard	50% (incentive levels do not apply; your medical plan may provide additional coverage — see the appropriate booklet)
Temporomandibular joint (TMJ) disorders	50% up to a $500 lifetime maximum for non-surgical treatment and appliances (incentive levels do not apply and this benefit doesn't apply to the annual maximum benefit; your medical plan may provide additional coverage — see the appropriate booklet)
Accidental injury	100% for covered expenses incurred within 180 days of accident (deductible doesn't apply)

Participating and Non-Participating Dentists

You may select any licensed dentist. Tell your dentist you're covered by a program administered by WDS for King County. The group number is 152. You must provide either your Social Security number or unique identifier (if assigned one by WDS).

If you go to a participating dentist, the dentist submits claim forms to WDS and receives payment directly. You are responsible for any remaining balance. If you see a non-participating dentist, it's your responsibility to see that the claim form is submitted (see "Filing a Claim" in this booklet).

Benefit Maximums

The maximum the plan pays each calendar year for most covered expenses is $2,000 per person. The lifetime maximum payable by WDS for orthodontic treatment is $2,500 per person. The lifetime maximum payable by WDS for TMJ treatment is $500 per person.

Charges for dental procedures requiring multiple treatment dates (such as crowns or bridgework) are considered incurred on the date the service is complete.

Incentive Program

WDS increases your payment levels through an incentive program as long as you see your dentist each year:

- For diagnostic and preventive services as well as basic services, the payment level starts at 70% and increases 10% in January of each year until you reach 100%
- For major restorative services the payment level increases from 70% to 80%, then to 85%

If you do not see the dentist during the calendar year, your payment level is reduced to the next lower payment level, but never below 70%. The reduction is from the level under which your last claim was paid. For example, if you saw your dentist in 2001 and your payment level was 80%, but you did not see your dentist in 2002, your payment level in 2003 is reduced from 80% to 70%.

Major prosthodontic services, orthodontia, TMJ treatment and night (occlusal) guards are not under the incentive program.

The following table summarizes how the incentive program works.

If you receive these services ...	The plan pays ...
Diagnostic and preventive services **Basic services**	70% first year 80% second year 90% third year 100% fourth year and each year thereafter
Major services – restorative	70% first year 80% second year 85% third year and each year thereafter

Example 1. This is Rachel's second year of plan participation. This year, Rachel visits her participating dentist for her annual cleaning. Since she visited the dentist last year, her coinsurance level for this year increased from 70% to 80%. She doesn't need to meet the annual deductible before the plan pays for covered diagnostic and preventive services. Here's how much Rachel pays:

Total Expense	Plan Pays	Rachel Pays
$ 45 Exam	$ 36 (80% of $45)	$ 9 (20% of $45) + 0 Deductible $ 9

The annual deductible does not apply to the type of service Rachel received (preventive).

Example 2. Jim has participated in this plan for three years, but hasn't been to the dentist during any of those years. This year Jim needs a root canal. Here's how much Jim pays:

Total Expense	Plan Pays	Jim Pays
$ 600 Root canal - 25 Deductible $ 575	$ 402.50 (70% of $575)	$ 172.50 (30% of $575) + 25.00 Deductible $ 197.50

The annual deductible does apply to the type of service Jim received (basic). His deductible for the calendar year is met on this claim.

Predetermination of Benefits

If you think your dental care will exceed $200 and for all orthodontic and TMJ services, ask your dentist to submit a standard WDS claim form for predetermination. This way you'll learn in advance exactly what procedures are covered, the amount WDS will pay toward the treatment and the amount you'll need to pay. (WDS conducts professional clinical reviews of basic and major services. If professional dental standards indicate that a condition can be treated by a less costly alternative to the service proposed by your dentist, WDS limits benefits to the less costly alternative, unless otherwise noted or restricted in the next section, "Covered Expenses under WDS." You are responsible for any treatment costs exceeding the allowable amounts paid by WDS.)

Predetermination requires notification or approval before you receive dental care. WDS will provide notice of the claim decision within 15 days after receiving your claim form. If a predetermination is filed improperly, WDS will provide notice of the improper filing and how to correct it within five days after receiving the predetermination filing. If more information is required, WDS will notify you of what is needed within 15 days after receiving the claim.

WDS may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension, you have 45 days to submit this information and WDS will make a determination within 15 days. If the information isn't submitted within 45 days, the claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan it's based on, and describe the claim appeal procedures (see "Appealing a Denied Claim" in this booklet for further details).

For an emergency, immediate treatment is allowed without predetermination and the claim is evaluated after treatment.

Covered Expenses under WDS

This section describes covered expenses and any related limits. To be covered, expenses must be medically necessary for treatment, diagnosis or prevention of a dental condition.

If professional dental standards indicate the condition can be treated by a less costly alternative to the service proposed by your dentist, in some cases this plan will limit benefits to the less costly alternative (WDS determines on a case-by-case basis). You are responsible for any treatment costs exceeding the allowable amounts paid by WDS (see "Predetermination of Benefits" above).

Diagnostic and Preventive Services

- WDS-approved caries (decay) susceptibility tests
- Exam – emergency
- Exam – routine, twice per calendar year
- Exam by a specialist in an American Dental Association-recognized specialty

- Fissure sealants for children through age 14 or younger; if eruption of permanent molars is delayed, sealants will be allowed if applied within 12 months of eruption with documentation from the attending dentist; payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface (the application of fissure sealants is a covered benefit only once in three years per tooth)
- Periodontal cleaning and maintenance or prophylaxis (cleaning), up to four times a calendar year (under certain oral health conditions)
- Preventive therapies, such as fluoridated varnishes, approved by WDS under certain conditions of oral health (when performed as the suggested regimen for that therapy); children through age 18 are eligible for either topical application of fluoride (as described below) or preventive therapies, but not both
- Prophylaxis (cleaning), twice per calendar year
- Space maintainers for the eruption of permanent teeth
- Topical application of fluoride twice per calendar year for children age 18 or younger
- X-rays (complete series or panorex), once in three years; supplementary bitewing x-rays, twice per calendar year.

Basic Services

- Amalgam, filled resin or composite fillings to treat decay or fracture resulting in significant tooth loss
- General anesthesia/intravenous sedation:
  - If administered by a licensed dentist or other WDS-approved licensed professional who meets the state Dental Quality Assurance Commission guidelines in conjunction with certain covered surgical procedures as determined by WDS
  - When medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures
- Localized delivery of chemotherapeutic agents approved by WDS under certain conditions of oral health when performed as the suggested regimen for that therapy; must be preceded by scaling and root planing at a minimum of six weeks and a maximum of six months or the patient must have been in active supportive periodontal therapy before the treatment
- Preparation of the alveolar ridge and soft tissue of the mouth for insertion of dentures
- Pulp exposure treatment, pulpotomy and apicoectomy
- Pulpal and root canal treatment (root canal treatment on the same tooth is covered once in two years)
- Removal of teeth and surgical extractions
- Restorations on the same surface(s) of the same tooth, once in two years (if a filled resin or composite filling is placed in a posterior tooth, the plan pays benefits as if it were an amalgam
- Stainless steel crowns, once in two years
- Surgical and non-surgical procedures to treat the tissues supporting the teeth, including exams, periodontal maintenance, periodontal scaling/root planing (once in 12 months), periodontal surgery and soft tissue grafts (once in three years per site); periodontal surgery must be preceded by scaling and root planing at a minimum of six weeks and a maximum of six months or the patient must have been in active supportive periodontal therapy before the treatment
- Treatment of pathological conditions and traumatic facial injuries.

If teeth are restored with crowns, inlays or onlays, refer to the following sections.

Major Services – Restorative

- Crowns (on the same teeth, once in five years)
- Onlays (on the same teeth, once in five years).

Gold, porcelain, WDS-approved gold substitute castings (except processed resin) or combinations of these may be used in major restorative services.

Crowns and onlays are covered only to treat decay or fracture resulting in significant tooth loss (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or resin.

Major Services – Prosthodontics

Dentures, fixed bridges, inlays if used as an abutment for a fixed bridge (on the same teeth, once in five years), removable partial dentures and adjustment or repair of an existing prosthesis unless limited by:

- Denture adjustments and relines done more than six months after the initial placement. These are covered, except as noted under temporary/interim dentures below. Subsequent relines or rebases, but not both, will be covered once in 12 months.
- Dentures (temporary/interim). If you receive an interim partial or full denture, the plan pays as if you received a reline. After placement of the permanent prosthesis, an initial reline is covered after six months.
- Dentures (partial). If a more elaborate or precision device is used, the plan pays as if you received a cast chrome and acrylic partial denture.
- Full, immediate and overdentures. For personalized restorations or specialized treatment, the plan pays as if you received a full, immediate or overdenture.
- Replacement of an existing prosthetic device. This is covered once in five years and only then if it's unserviceable and cannot be made serviceable.
- Replacement of implants and superstructures, covered only after five years have elapsed from any prior implant.
- Root canal treatment performed in conjunction with overdentures. This is limited to two teeth per arch.
- Surgical placement or removal of implants or attachments to implants.

Orthodontic Services

This plan covers orthodontic care for adults and children. All orthodontic treatment must be authorized by WDS before treatment begins (see "Predetermination of Benefits" in this booklet).

Other Services

- Night (occlusal) guard once in three years
- Nonsurgical treatment and appliances to treat temporomandibular joint (TMJ) disorders.

Accidental Injury

The plan pays 100% of covered expenses directly resulting from an accidental bodily injury, up to the annual maximum, if for diagnosis and treatment performed/incurred within 180 days after the accident. The accidental bodily injury and treatment must have occurred while the patient was eligible. Payment for accidental injury claims will not exceed the unused maximum. A bodily injury does not include teeth broken or damaged while chewing or biting on foreign objects.

Expenses Not Covered

In addition to the exclusions or limits described in other sections of this booklet, the WDS plan does not cover:

Diagnostic and Preventive Services

- Cleaning of prosthetic appliances
- Consultations or elective second opinions
- Plaque control program (oral hygiene instruction, dietary instruction or home fluoride kits)
- Replacement of a space maintainer previously paid for by WDS
- Study models.

Basic Services

- Bleaching of teeth
- Crowns as part of periodontal therapy
- Gingival curettage
- Iliac crest or rib grafts to alveolar ridges
- Localized delivery of chemotherapeutic agents when used to maintain non-covered dental procedures or implants
- Occlusal splints
- Overhang removal, recontouring or polishing of restoration
- Periodontal appliances
- Periodontal splinting or crown and bridgework in conjunction with periodontal splinting
- Restorations necessary to correct vertical dimension or to modify shape of teeth or occlusion
- Ridge extension for insertion of dentures
- Tooth transplants.

Major Services

- Cleaning of prosthetic appliances
- Crowns or copings in conjunction with overdentures
- Crowns or onlays placed because of weakened cusps or existing large restorations without overt disease
- Crowns used as an abutment to a partial denture for recontouring, repositioning or increasing retention (unless the tooth is decayed to the extent that a crown would be needed whether or not a partial denture is required)
- Crowns used to repair micro-fractures of tooth when it displays no symptoms or existing restorations with defective margins when no disease exists
- Duplicate dentures
- Personalized dentures.

What Happens If

If You Need Emergency Care

If you need emergency dental care, you may see either a participating or non-participating dentist. Your benefits depend on the type of services you receive (see "Summary Table" and "Incentive Program" in this booklet for benefit levels).

If You Need Care While Traveling

If you receive treatment from a dentist outside Washington State, you pay the dentist in full, then submit a claim form as described in "Filing a Claim" in this booklet. Payment is based on the dentist's charge, or the amount that would have been payable if treatment had been provided by a participating WDS dentist, whichever is less.

If Your Family Member Lives Away from Home

Family members who live away from home either temporarily or permanently may see a non-participating dentist and still receive benefits from this plan. Your family member must file a claim (see "Filing a Claim" in this booklet).

Coordination of Benefits between Plans

King County plans coordinate benefits under a non-duplication policy between primary and secondary plans. That means if a plan is primary, it pays first; if it is secondary, it pays only the difference between what the primary plan paid and what the secondary plan would have paid if it was primary.

If you and a family member both have your own health coverage (medical, dental and vision) and you cover each other as dependents under your plans, your own plans are primary for each of you and secondary for each other.

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine what plan is primary for dependent children covered under two parents ("parents" in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- If the parents are divorced or legally separated, these rules apply:
  - If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first.
  - If there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody.
  - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer these coordination of benefit procedures.

Filing a Claim

What to Do

If you receive care from a participating provider, the provider submits claims for you. If you receive services from a non-participating provider, you pay the provider in full, and it's your responsibility to submit a claim form to WDS or have the provider submit one for you. Claim forms are available from WDS (see Resource Directory booklet).

When submitting any claim, you need to include your itemized bill. It should show:

- Patient's name
- Provider's tax ID number
- Diagnosis or CDT-4 code
- Date of service/supply
- Itemized charges from the provider for the services/supplies received.

You also need to provide:

- Your name (if you were not the patient)
- Your Social Security number (or unique identifier number if assigned one by your plan)
- Group number 152.

For prompt payment, submit all claims as soon as possible. The plan will not pay a claim submitted more than 12 months after the date of service/supply. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

How the Claim is Reviewed

WDS will review your claim and notify you or your provider in writing within the following timeframes:

- **Within 72 hours for urgent claims.** Urgent claims are claims for services where your provider believes a delay in treatment could seriously jeopardize your life, health or ability to regain maximum function, or cause severe pain that can't be controlled adequately without the care being considered. Urgent claims can be submitted by phone. You will be notified of the claim review decision by phone with a written notice to follow.
- **Within 15 days for pre-service claims (within 30 days if an extension is filed).** Pre-service claims are those where the plan requires you to obtain approval of the benefit before receiving the care. The plan may ask for a one-time extension of 15 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.
- **Within 24 hours for concurrent claims.** Concurrent claims are those for continuation of services previously approved by the claim administrator as an ongoing course of treatment or to be provided over a certain period.
- **Within 30 days for post-service claims (within 60 days if an extension is filed).** Post-service claims are claims that aren't urgent, pre-service or concurrent. The plan may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claim administrator reviews your claim, applying plan provisions and their discretion in interpreting plan provisions, and then notifies you of the decision within the timeframes listed above.

If the Claim is Approved

If the claim is approved and there is no indication the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

If the Claim is Denied

If the claim is denied, you are notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that WDS reviewed in making the determination.

Appealing Denied Claims

Claims Denied for Reasons Other Than Eligibility

If a properly filed claim is denied in whole or in part, WDS notifies you and your provider with an explanation in writing. When a claim is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim is denied for eligibility reasons, follow the steps described in the next section, "Claims Denied Due to Eligibility."

If you or your representative disagrees with the claim denial, you may try to resolve any misunderstanding by calling WDS and providing more information. If you'd rather communicate in writing or the issue isn't resolved with a call, you may file a written appeal (see the Resource Directory booklet for contact information).

You have 180 days after receiving a claim denial notice to file a written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

WDS will review the written appeal and notify you or your representative of their decision within these timeframes:

- Within 72 hours for urgent appeals
- Within 15 days for pre-service appeals
- Within 30 days for post-service appeals

- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

Your appeal is reviewed by someone different from the original decision makers and without deference to the initial decision. The appeal reviewer applies the plan provisions and their discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above. If the claim appeal is denied, you are notified in writing of reasons for the denial.

If you disagree with the appeal decision, you may submit the matter to a mutually agreed upon nonbinding mediator. If you and WDS cannot agree upon a mediator within 15 days, WDS will submit the matter to the American Arbitration Association or Judicial Arbitration and Mediation Service.

WDS has sole discretionary authority to determine benefit payment under the plans; their decisions are final and binding.

If the appeal is denied, legal remedies may be pursued, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within six years after the event the claim is based on or you forfeit your right to legal action.

Claims Denied Due to Eligibility

If you have eligibility questions or believe you've had a claim denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of the section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these timeframes:

- Within 72 hours for urgent appeals (call 206-684-1556 to file an urgent appeal)
- Within 14 days for pre-service appeals (within 30 days if an extension is filed)
- Within 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice includes the plan provision behind the decision and advises you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the

plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Certificate of Coverage

When your coverage under this plan ends, you automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan.

Payment of Dental Benefits

The dental benefits offered by this plan are funded by King County, making this a "self-funded" plan. Though Washington Dental Service is responsible for the payment of claims, King County is financially responsible for the cost of those claims.

Booklet 5

Vision Service Plan

Although these benefit descriptions include certain key features and brief summaries of King County regular employee and part-time Local 587 benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

Table of Contents: Vision Service Plan

Overview

Highlights of Coverage under Vision Service Plan (VSP)

Here are a few highlights of your vision benefits:

- You can use any eye care provider you wish, but benefits are generally higher (your out-of-pocket expenses are less) if you see a VSP provider
- The plan pays benefits if you see a VSP participating or non-VSP provider (optometrist or ophthalmologist)
- Participating VSP providers automatically file claims for you; if you see a non-VSP provider, you must pay the provider in full at the time of service and then submit a claim to VSP for reimbursement.

Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:

- Who's eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and the options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

When you receive routine vision services from a VSP provider, you pay a $10 copay to the provider once during any 12-month period.

When you receive services from a non-VSP provider, up to a $10 copay may be deducted from your reimbursement. The plan reimburses you up to the dollar amounts shown in the "Summary Table" on the next page, and any amount you pay in excess of the amounts shown is credited against the $10 copay. For example, if you pay $47 for an eye exam ($7 more than the amount VSP reimburses for a non-VSP provider eye exam), VSP deducts only $3 from your reimbursement for the copay.

You are responsible for expenses not covered by this plan.

See "How the Plan Works" (next section) for more information; also see the latest new hire guides and open enrollment materials for details about monthly premiums you must pay (if any) for the coverage.

How the Plan Works

Summary Table

The table on the following page summarizes covered eye care services and eyewear under this plan and identifies related limits (see "Covered Expenses under VSP" and "Expenses Not Covered" in this booklet for more details).

Vision Service Plan		
Covered Expenses	**If you see a VSP provider you pay a $10 copay (once during any 12 month period) and the plan pays …**	**If you see a non-VSP provider you pay the bill in full and the plan reimburses you the following amounts, minus a maximum $10 copay* (once during any 12-month period) …**
Exams (once every 12 months)	100%	Up to $40
Lenses (1 pair every 12 months)		
• Single vision	100%	Up to $40
• Bifocal	100%	Up to $60
• Trifocal	100%	Up to $80
• Lenticular	100%	Up to $125
• Progressive	100%	Up to $5 for upgrade to progressives, tints and coatings combined
• Tints	100%	
• Coatings	100%	
Frames (once every 24 months)	Covered up to $130; if you choose a frame that costs more than the VSP allowable amount, you'll receive 20% off your out-of-pocket costs	Up to $45
Contacts (once every 12 months in place of eyeglass lenses and frames)		
• Elective (providers may bill you for contact lenses separately or they may include the lenses, fittings and follow-up fees in a single bill; all of these contact lens fees apply to the $105 maximum paid by the plan)	100% up to $105	Up to $105
• Medically necessary (see "Covered Expenses under VSP" for details)	100%	Up to $210

* Your copay depends on the amount your non-VSP provider charges and the amount VSP pays for the covered expense (see "Cost" in this booklet for details).

VSP Providers

VSP has an extensive nationwide network of private-practice providers (optometrists and ophthalmologists). To find a participating VSP provider near your home or work, contact VSP (see the Resource Directory booklet).

Accessing Care

Under this plan, you can use any eye care provider you wish, VSP or non-VSP. However, if you see a VSP provider, you receive higher benefits, claims automatically are filed for you and VSP can guarantee patient satisfaction.

To receive VSP-level benefits:

- Make an appointment with your VSP provider. Be sure to identify yourself as a VSP member and give the employee's Social Security number. The VSP provider notifies you if any services you're requesting are not covered.
- Pay a $10 copay when you meet with the provider (you pay only once during any 12-month period).

- The plan pays 100% for most covered services.

You do not need to file claims. Your provider and VSP handle the rest by verifying your benefits and eligibility for services.

To receive non-VSP-level benefits:
- Make an appointment with any licensed eye care provider. If you want to verify that the care you'll receive is covered, contact VSP (see the Resource Directory booklet).
- Pay the bill in full at the time of service.
- File a claim to VSP for reimbursement.

Covered Expenses under VSP

This section describes expenses covered by your VSP benefits. For information on the level of benefits you receive (for example, related limits) see "Summary Table" in this booklet.

Covered vision expenses include:
- Vision exams – a complete analysis of the eye and related structures to determine the presence of vision problems or abnormalities
- Elective contact lenses
- Frames
- Medically necessary contact lenses when preauthorized by VSP and prescribed by an eye care provider for the visual welfare of the patient due to specific medical conditions such as:
  - Cataract surgery
  - Conditions of anisometropia
  - Extreme visual acuity problems that cannot be corrected with eyeglasses
  - Keratoconus
- Spectacle lenses (progressive multifocal lenses are covered when you see a VSP provider).

VSP providers generally require two to three working days to make lenses, based on the lab and eyewear selected. If you don't have a back-up pair of glasses and would like faster turnaround, your provider may be able to accommodate you, depending on their arrangements with the lab. The cost and arrangements vary by provider; contact your VSP provider for details.

Helpful Hint. Each time you receive contact lenses under the plan, you must wait 12 months before you are eligible for lenses (spectacle or contact) and 24 months before you're eligible for frames. If you are interested in getting both glasses and contacts, purchase the glasses first, then you can replace lenses (either contact lenses or spectacle lenses) each year.

Extra-Cost Items

This plan is designed to pay the cost of visual rather than cosmetic needs. You pay the extra cost for:
- Amounts over the low-vision benefit maximum
- Frames above the plan allowance
- Optional cosmetic services, procedures, and eyewear.

A VSP provider can tell you the additional charges for these items.

Low-Vision Benefit

If you have severe visual problems that are not correctable with regular lenses, you may be eligible for the low-vision benefit. To receive this benefit, you may see either a VSP or non-VSP provider, and you must:
- Obtain authorization from VSP before you receive services
- Pay a copay equal to 25% of the cost of services.

The plan pays 100% (after the copay) for analysis and diagnosis, including a comprehensive exam of visual functions, with a prescription for corrective eyewear or vision aids where indicated. The low-vision benefit maximum is $1,000 (excluding the copay) every two years.

If you see a non-VSP provider, you must pay the provider in full and file a claim with VSP for reimbursement. The benefits will not be more than the amount payable had you seen a VSP provider.

Additional VSP Provider Benefits

Discount for Extra Frames and Lenses

You may purchase an additional pair of frames and prescription lenses from your VSP provider at a 20% discount. To receive this discount, you must make the additional purchase within 12 months of your initial exam and from the same VSP provider.

Discount for Prescription Contact Lenses

If you see the same VSP provider for a second exam in a 12-month period, and the purpose is to fit you for prescription contact lenses, you'll receive a 15% discount toward the exam and any follow-up services.

Discount for Laser Vision Correction

VSP has arranged for plan participants to receive laser vision correction from VSP-approved surgeons and laser centers for a discounted fee. Discounts vary by location, but average 15% to 20%. The laser centers may offer an additional price reduction, where VSP participants receive 5% off the advertised price if less than the usual discounted price.

To obtain laser vision services:
- Call your VSP provider to check if he/she participates in the program or contact VSP to locate a participating provider (see the Resource Directory booklet).
- Schedule a free screening and consultation on the advantages and risks of laser vision correction. Your VSP provider will give preoperative care and make arrangements with the VSP-approved surgeon and laser center. (While the screening and consultation are complimentary, if you have a preoperative exam and do not proceed with the surgery, your VSP provider may charge a discounted exam fee up to $100.)

Post-procedure care is coordinated between your VSP provider (optometrist or ophthalmologist) and your VSP surgeon and laser center.

Expenses Not Covered

In addition to the exclusions or limits described in other sections of this booklet, VSP does not cover:
- Blended lenses (see definition of this term and progressive lenses in the Glossary booklet)
- Costs that exceed plan allowances
- Exams or eyewear required as a condition of employment
- Extra-cost items, as described in this booklet
- Medical or surgical treatment of the eye (see the appropriate medical plan booklet for information on coverage for these expenses)
- Orthoptics or vision training and any associated supplemental testing
- Oversized lenses (61 mm or larger)
- Plano (non-prescription) lenses
- Replacement of lost or broken lenses and frames, except at normal intervals – once every 12 months for lenses (spectacle or contact) and once every 24 months for frames (if frames are broken as the lenses are being inserted, VSP may cover the cost, depending on the age and condition of the broken frames; contact VSP for details)

- Services or materials provided as a result of workers compensation law or similar legislation, or obtained through or required by any government agency or program
- Two pairs of glasses in place of bifocals.

What Happens If

If You Need Emergency Care

If you need immediate and unexpected vision care (for example, because of a sudden change in your sight) or vision hardware (for example, you break your glasses), you may see either a VSP or non-VSP provider and receive VSP-level benefits up to any applicable limits. For care beyond this initial emergency, you'll need to see a VSP provider to receive VSP-level benefits. (See "Summary Table" in this booklet for details on limits and benefit levels.)

If You Need Care While Traveling

If you need immediate and unexpected vision care (as described above) while you're traveling, you may see either a VSP or non-VSP provider. Benefits depend on whether you choose a VSP or non-VSP provider and are paid at the level shown in "Summary Table" in this booklet

The VSP network of providers is nationwide. To find one in your immediate area, call VSP at the number in the Resource Directory booklet.

If Your Family Member Lives Away from Home

Family members who live away from home temporarily or permanently may see a VSP or a non-VSP provider. Benefits depend on whether they choose a VSP or non-VSP provider and are paid at the level shown in the "Summary Table" in this booklet.

Coordination of Benefits between Plans

King County plans coordinate benefits under a non-duplication policy between primary and secondary plans. That means if a plan is primary, it pays first; if it is secondary, it pays only the difference between what the primary plan paid and what the secondary plan would have paid if it was primary.

If you and a family member both have your own health coverage (medical, dental and vision) and you cover each other as dependents under your plans, your own plans are primary for each of you and secondary for each other.

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine what plan is primary for dependent children covered under two parents ("parents" in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- If the parents are divorced or legally separated, these rules apply:
  - If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first
  - If there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody
  - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer these coordination of benefit procedures.

Filing a Claim

What to Do

If you receive care from a VSP provider, the provider submits claims for you. If you receive services from a non-VSP provider, you pay the provider in full, and it's your responsibility to submit a claim form to VSP or have the provider submit one for you. Claim forms are available from VSP (see the Resource Directory booklet).

When submitting any claim, you need to include your itemized bill. It should show:
- Patient's name
- Provider's tax ID number
- Date of service/supply
- Itemized charges from the provider for the services/supplies received.

You also need to provide:
- Your name (if you were not the patient)
- Your Social Security number (or unique identifier number if assigned one by your plan).

For prompt payment, submit all claims as soon as possible. The plan will not pay a claim submitted more than 12 months after the date of service/supply. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

How the Claim is Reviewed

VSP will review your claim and notify you or your provider in writing within the following timeframes:
- **Within 72 hours for urgent claims.** Urgent claims are claims for services where your provider believes a delay in treatment could seriously jeopardize your life, health or ability to regain maximum function, or cause severe pain that can't be controlled adequately without the care being considered. Urgent claims can be submitted by phone. You will be notified of the claim review decision by phone with a written notice to follow.
- **Within 15 days for pre-service claims (within 30 days if an extension is filed).** Pre-service claims are those where the plan requires you to obtain approval of the benefit before receiving the care. The plan may ask for a one-time extension of 15 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.
- **Within 24 hours for concurrent claims.** Concurrent claims are those for continuation of services previously approved by the claim administrator as an ongoing course of treatment or to be provided over a certain period.
- **Within 30 days for post-service claims (within 60 days if an extension is filed).** Post-service claims are claims that aren't urgent, pre-service or concurrent. The plan may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claim administrator reviews your claim, applying plan provisions and their discretion in interpreting plan provisions and then notifies you of the decision within the timeframes listed above.

If the Claim is Approved

If the claim is approved and there is no indication the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

If the Claim is Denied

If the claim is denied, you are notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that VSP reviewed in making the determination.

Appealing Denied Claims

Claims Denied for Reasons Other Than Eligibility

If a properly filed claim is denied in whole or in part, VSP notifies you and your provider with an explanation in writing. When a claim is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim is denied for eligibility reasons, follow the steps described in the next section, "Claims Denied Due to Eligibility."

If you or your representative disagrees with the claim denial, you may try to resolve any misunderstanding by calling VSP and providing more information. If you'd rather communicate in writing or the issue isn't resolved with a call, you may file a written appeal with VSP (see the Resource Directory booklet for contact information).

You have 180 days after receiving a claim denial notice to file a written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

VSP will review the written appeal and notify you or your representative of its decision within these timeframes:

- Within 72 hours for urgent appeals
- Within 30 days for pre-service appeals
- Within 30 days for post-service appeals (first and second level appeals)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

Your appeal is reviewed by someone different from the original decision makers and without deference to the initial decision. The appeal reviewer applies plan provisions and their discretion in interpreting plan provisions, and then notifies you of the decision within the timeframes listed above. If the claim appeal is denied, you are notified in writing of reasons for the denial.

If you disagree with the resolution of your claim, you have 60 days after receiving the denial to submit a second level appeal with any further documentation to VSP.

VSP has sole discretionary authority to determine benefit payment under the plans; its decisions are final and binding.

If the appeal is denied, legal remedies may be pursued, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on or you forfeit your right to legal action.

Claims Denied Due to Eligibility

If you have eligibility questions or believe you've had a claim denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of the section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these timeframes:

- Within 72 hours for urgent appeals (call 206-684-1556 to file an urgent appeal)
- Within 14 days for pre-service appeals (within 30 days if an extension is filed)
- Within 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees.

Decisions of the manager are final and binding. If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Certificate of Coverage

When your coverage under this plan ends, you automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan.

Payment of Vision Benefits

The vision benefits offered by this plan are funded by King County, making this a "self-funded" plan. Though Vision Service Plan is responsible for the payment of claims, King County is financially responsible for the cost of those claims.

Booklet 6

Aetna Life Insurance

Although these benefit descriptions include certain key features and brief summaries of King County regular employee and part-time Local 587 benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

Table of Contents: Aetna Life Insurance

Overview

Highlights of Aetna Life Insurance

Here are a few highlights of your life insurance:

- Basic and enhanced life insurance is provided by Aetna Life Insurance Company
- If you're a part-time Local 587 employee in Plan 1, you may purchase basic life insurance for yourself
- If you're a regular employee or part-time Local 587 employee in Plan 2 or Plan 3:
  - You automatically receive basic life insurance paid by the county
  - You may purchase additional ("enhanced") life insurance for yourself and family members
  - You must enroll in enhanced life insurance to enroll your eligible family members
- Accelerated or living benefits may be available in the event of terminal illness
- Premium waiver may be available if you become disabled
- You have options to continue life insurance when you leave county employment.

Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:

- Who's eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

Basic Life

The county pays the cost of basic life insurance for regular employees and part-time Local 587 employees in Plan 2 or 3.

You pay the cost if you are a part-time Local 587 employee in Plan 1. Premiums for Plan 1 coverage are paid through payroll deduction and the cost is based on different age groups. Premiums are adjusted the month of your birthday if your birthday moves you into a different group.

Under IRS regulations, $50,000 is the maximum coverage an employer may provide to you tax free. If you're a regular employee, your basic life insurance coverage may exceed $50,000. When this is the case, you pay the income tax (determined by the IRS) on the value of county-paid premiums applicable to your coverage above $50,000. The value is added to your paycheck and reflected in your W-2 earnings as imputed income.

Enhanced Life

If you're eligible and elect enhanced life insurance, you pay a monthly premium through payroll deduction. Cost depends on the amount of insurance you elect, your base annual salary and different age groups. Premiums are adjusted the month of your birthday if your birthday moves you into a different group.

If you cover a spouse/domestic partner at 50% of your enhanced amount, the cost is 50% of what you pay for your own enhanced insurance (cost is based on your age group). If you cover children, the cost is a flat rate no matter how many children you cover. See the latest new hire guides and open enrollment materials for information about the monthly cost of coverage.

Amount of Coverage

If You're a Regular Employee

Basic Life for You. You automatically receive county-paid basic life insurance. If you die, the beneficiaries you designate receive a lump sum equal to your base annual salary (rounded to the next higher $1,000, with a maximum of $200,000). The lump sum is divided among your beneficiaries according to your beneficiary designation.

Your base annual salary is your base pay excluding overtime, bonuses or premium or any other special pay.

Enhanced Life for You. You may purchase enhanced life insurance equal to 1, 2, 3 or 4 times your base annual salary (rounded to the next higher $1,000) without evidence of insurability (EOI). The cost you pay for the amount you choose is based on your age. If you die, your beneficiaries receive the amount you elect in addition to your county-paid basic life insurance benefit. The maximum enhanced life insurance coverage you may have is $400,000.

Enhanced Life for Your Family. If you elect enhanced life insurance for yourself, you may purchase enhanced life for family members:

- Spouse/domestic partner at 50% of your enhanced amount up to $200,000 (EOI is required only if the amount exceeds $100,000)
- Child(ren) at $10,000 each for ages 6 months to 23 years and $500 for ages 14 days to 6 months (if you cover one child, all your eligible children are covered for $10,000 each; no EOI is required).

If you and your spouse/domestic partner both work for King County, you may not cover each other, and only one of you may cover your eligible children under this plan. However, you may add your spouse/domestic partner and children for coverage if they lose their county coverage (see "Changes You May Make When a Qualifying Change Occurs" in the Important Facts booklet).

Increases in Coverage. Since your coverage amount is a multiple of your salary, both your basic and enhanced coverage automatically increase as your salary increases (subject to the basic and enhanced maximums).

If you elect enhanced coverage for your spouse/domestic partner, it automatically increases as your salary increases. No EOI is required if the spouse/domestic partner coverage exceeds $100,000 due solely to a salary increase. (Since children are covered for a flat amount not based on your salary, their coverage is not affected by increases in your salary.)

Adjustments to the life insurance benefit due to a benefit request or salary change automatically occur the first of the month following approval of the request or change, if you are actively at work that day. If the change occurs on the first of the month, the adjustment becomes effective the same day. Otherwise the adjustment occurs on the first of the month following the date you return to active work.

If You're a Part-Time Local 587 Employee

Plan 1 Basic Life for You. You may purchase basic life insurance when you are first eligible for Plan 1. If you elect basic life and die, the beneficiaries you designate receive a lump sum payment of $20,000. The lump sum is divided among your beneficiaries according to your beneficiary designation.

Plan 2 or 3 Basic Life for You. You automatically receive county-paid basic life insurance. If you die, the beneficiaries you designate receive a lump sum payment of $25,000. The lump sum is divided among your beneficiaries according to your beneficiary designation.

Plan 2 or 3 Enhanced Life for You. You may purchase enhanced life insurance of $25,000, $50,000, $75,000 or $100,000 without evidence of insurability (EOI). If you die, the beneficiaries you designate receive the amount you elect in addition to your county-paid basic life insurance benefit.

Plan 2 or 3 Enhanced Life for Your Family. If you elect enhanced life insurance for yourself, you may purchase enhanced life for family members:

- Spouse/domestic partner at 50% of your enhanced amount (no EOI is required)
- Child(ren) at $10,000 each for ages 6 months to 23 years and $500 for ages 14 days to 6 months (if you cover one child, all your eligible children are covered for $10,000 each; no EOI is required).

If you and your spouse/domestic partner both work for King County, you may not cover each other, and only one of you may cover your eligible children under this plan. However, you may add your spouse/domestic partner and children for coverage if they lose their county coverage (see "Changes You May Make When a Qualifying Change Occurs" in the Important Facts booklet).

Evidence of Insurability

EOI is any statement of proof of a person's physical condition, occupation or other factor affecting his or her acceptance for insurance. An EOI application is provided by Benefits and Retirement Operations when EOI is required under the policy. The application should be completed and returned directly to Aetna within 31 days of receipt.

EOI is required for a spouse/domestic partner when coverage is requested in an amount greater than $100,000 (EOI is not required if coverage subsequently exceeds $100,000 as the result of employee salary increases). The coverage amount above $100,000 does not become effective until the proof of good health is approved by Aetna. If EOI is not received or approved, coverage is capped at $100,000.

No EOI is required for eligible children.

Beneficiaries

All employees (except part-time Local 587 employees in Plan 1 who don't elect basic coverage) receive a life insurance benefit and need to designate one or more beneficiaries – individuals who receive your benefit in the event of your death. A Beneficiary Designation form is provided when you first enroll and is available on the Web and from Benefits and Retirement Operations anytime you need to change beneficiaries (see Resource Directory booklet).

You may name anyone you wish as your primary or contingent beneficiaries (contingent beneficiaries receive benefits if all primary beneficiaries are deceased at the time of your death). If you don't designate beneficiaries as primary or contingent on your Beneficiary Designation, all beneficiaries you list are considered primary.

You may designate more than one primary and one contingent beneficiary. When you do, you must assign the percentage of your benefit each beneficiary receives on your Beneficiary Designation. Percentages for all primary beneficiaries must total 100% and percentages for all contingent beneficiaries must total 100%. If you don't assign percentages, beneficiaries receive equal shares.

If you're married and do not choose to list your spouse as your only primary beneficiary, your spouse must sign the spouse waiver section of the Beneficiary Designation.

You may change your beneficiary at any time by completing a new Beneficiary Designation and sending it to Benefits and Retirement Operations. Benefits are paid according to the most recently signed form on file. If you don't name a beneficiary, benefits are paid to your spouse, your children, your parents or your siblings, in that order. If none of them survives you, benefits are paid to your estate.

If you elect enhanced life coverage for your family members and a covered family member dies, you are the beneficiary.

When Benefits Are Payable

Death Benefits

Life insurance benefits are payable if you or a family member dies. However, if a beneficiary is implicated in the death of the insured and convicted of the crime, the law usually prohibits the beneficiary from receiving the benefits. Benefits may then be distributed to the contingent beneficiary.

Insurance is paid in a lump sum and not subject to federal income tax (consult your tax advisor for more information on taxes and death benefits).

This is how a lump sum is paid: when a death benefit of $10,000 or more is payable to you or a beneficiary, it is deposited into an Aetna Benefits Checkbook Account in the person's name. This account will earn competitive money market interest rates. You (or the beneficiary) receive personalized checks for immediate access to all or part of the funds deposited in the account and may write a check for no less than $250.

Accelerated Benefits

In the case of your or your covered spouse/domestic partner's terminal illness, certain benefits may be paid to you before death. You may elect to receive up to 50% of the life insurance benefit (to a maximum of $100,000 for a spouse/domestic partner; to a maximum of $300,000 for yourself) while you or your spouse/domestic partner is living if the following requirements are met:

- Life expectancy must be 24 months or less
- Certification of the terminal illness must be provided by a physician legally licensed to practice medicine and accepted by Aetna before accelerated benefits are payable.

While an accelerated benefit claim is pending, Aetna has the right, as often as reasonably necessary, to have a covered person examined by a health or vocational professional of Aetna's choice and at Aetna's expense.

Accelerated benefits are based on the amount of life insurance in effect according to county payroll records on the date Aetna accepts the physician's certification of terminal illness. Accelerated benefits are payable to you in a lump sum. The life insurance benefit is reduced by the amount of the accelerated benefit payment, and the remaining benefit is paid to you (or your beneficiary) after death.

Contact Benefits and Retirement Operations for more details about the accelerated benefit option. If you have enhanced life coverage and elect the accelerated benefit, you must continue paying for the enhanced coverage until the coverage ends.

Keep in mind:

- Accelerated benefits can be used to pay for special nursing requirements or hospice arrangements, needed medical equipment or custodial care and other expenses
- Accelerated benefits are payable only once for you and once for your spouse/domestic partner
- Your accelerated benefit payment reduces the amount of your life insurance benefit that may be converted to an individual policy
- You are responsible for any taxes due to an accelerated benefit payment
- Your spouse/domestic partner must agree with your accelerated benefit election.

Disability Provision

If You Become Disabled Before Age 60

If you become disabled before age 60 and notify Benefits and Retirement Operations within 30 days of your last day worked, the county pays to continue the basic life coverage you had on your last day worked and you have the option of paying to continue the enhanced life coverage you had on your last day for up to 12 months.

Between eight and nine months following your last day worked, apply to Aetna for a premium waiver. If Aetna determines your disability is permanent and total (approves your premium waiver application), it extends the basic and enhanced life coverage you had on your last day worked from the date of its determination until you reach age 65, at no cost to you as long as you remain disabled. (You may apply for premium waiver up to 12 months following your last day worked, but applications received after 12 months may be denied.)

If you convert coverage when you end employment (see "Converting to Individual Whole Life Insurance") and you are then approved for premium waiver, Aetna will cancel the individual policy and return the premiums to you.

You are permanently and totally disabled only if disease or injury stops you from working at your own job or any other job for pay or profit, and it must continue to stop you from working at any reasonable job. A "reasonable job" is defined as any job for pay or profit that you are (or may reasonably become) fitted for by education, training or experience.

To be eligible for premium waiver, you must meet all these requirements:
- Your life insurance must be in force when you become permanently and totally disabled
- You must be under age 60 on the date you last worked
- Your permanent and total disability must have lasted for at least nine months
- You must furnish all proof when requested (Aetna may ask you to have an exam, at its expense, before accepting the proof).

Premium waiver coverage ends when the first of these dates occurs:
- Aetna sends you a request for an exam, but you do not have the exam within 31 days of that date, or Aetna requests proof that you're still permanently and totally disabled and you don't provide the proof within 31 days of that date
- You are well enough to work in any reasonable job
- You start to work in any job for pay or profit
- You reach age 65.

After this coverage has been extended continuously for two years, Aetna will not request an exam or proof more often than once in 12 months. When the extended coverage period ends, you may be eligible to convert to an individual life insurance policy.

If you die while disabled, within 12 months of your last day worked and before applying for a premium waiver (or your application is approved), Aetna pays your beneficiaries the life insurance benefit they would have received had a premium waiver been approved. To pay this benefit, Aetna must receive written notice of your death within 12 months of its occurrence and proof your disability was permanent and total.

If You Become Disabled After Age 60

If you become disabled after age 60, before you retire or end county employment, and notify Benefits and Retirement Operations within 30 days of your last day worked, the county pays to continue the basic life coverage you had on your last day for up to 12 months or age 65, whichever occurs first. You also have the option of paying to continue the enhanced life coverage you had on your last day for up to 12 months or age 65, whichever occurs first.

Between eight and nine months following your last day worked, apply to Aetna for a disability determination. If Aetna determines your disability is permanent and total, the county will pay to continue your basic life coverage until you reach age 65, as long as you remain disabled and as long as the county continues to provide the benefit to its active employees.

If you do not apply between eight and nine months or your disability determination is not approved by Aetna, your county-paid basic life insurance ends after 12 months or at age 65, whichever occurs first. When this occurs, you may convert to individual coverage (see "Converting to Individual Whole Life Insurance" in this booklet).

Filing a Claim

For a death or accelerated claim, you or your beneficiary should contact Benefits and Retirement Operations. Benefits and Retirement Operations staff will help file the claim with Aetna and provide referrals to counseling and other resources as requested.

Aetna processes the claim within 90 days of receipt. If Aetna needs more time, you or your beneficiary are notified in writing, before the initial 90 days end, of the need for an extension of up to 90 days.

Aetna may, at its own expense, have an autopsy performed to determine a death benefit payment, unless prohibited by law.

If the claim is denied, you or your beneficiary are notified in writing of reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that the plan reviewed in making the determination.

Appealing Denied Claims

Claims Denied for Reasons Other Than Eligibility

When a claim is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim is denied for eligibility reasons, follow the steps described in the next section, "Claims Denied Due to Eligibility."

If you or your beneficiary disagrees with a claim denial, you, your beneficiary or representative (referred to as "you" in the rest of this section) may try to resolve any misunderstanding by calling Aetna and providing more information. If you'd rather communicate in writing or the issue isn't resolved with a call, you may file a written appeal. You have 60 days after receiving a claim denial notice to file the written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

Aetna will review the written appeal and notify you of its decision within 60 days after receiving the appeal. If Aetna requires additional time, you will be notified in writing that an additional period of up to 60 days is necessary.

Aetna will give you a written decision and explain the specific plan provisions behind the denial (if applicable).

Aetna has sole discretionary authority to determine benefit payment under the life insurance plan; its decision is final and binding. In reviewing your claim, Aetna applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Aetna determines you're entitled to the benefits.

If the appeal is denied, you may pursue legal remedies, but you must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on. If you do not file a claim or appeal within the specified period, you forfeit the right to further appeal.

Claims Denied Due to Eligibility

If you have eligibility questions or believe you've had a claim denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you, your beneficiary or your representative (referred to as "you" in the rest of this section) may file a written appeal. You have 60 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you in writing of the eligibility determination within 60 days. If additional time is required, you will be notified in writing that an additional period of up to 60 days is necessary.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an appeal addendum within 30 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation. It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you were denied plan participation, or you forfeit your right to legal action.

Continuation of Coverage

Continuing Group Term Life Insurance

When you end employment with the county for reasons other than retirement or disability, you may continue the basic and enhanced group term life insurance that you had on your last day of employment up to $300,000. This is called "portability." Premiums for the continued coverage are paid directly to Aetna and the age-specific group rates may differ from the rates paid by active employees.

If you continue coverage, you may also continue the enhanced group term life insurance you had on your last day of employment for your spouse/domestic partner until he or she is age 65 up to $25,000 and your dependent children's benefits until they are age 19 (23 if solely dependent on you for support) up to $5,000.

Employee or covered family member life benefits in excess of the portability maximums may be converted to a whole life policy (see "Converting to Individual Whole Life Insurance").

Portability coverage reduces to 25% at age 65 and terminates when you turn age 75 or otherwise stop premium payments for continued benefits. Continued coverage for your spouse/domestic partner and children ends when they attain the limiting age or when your benefits cease; however, they may convert to an individual whole life insurance policy (see "Converting to Individual Whole Life Insurance" below).

To continue coverage, you must request a Portability Application from Aetna and return the completed form with your first premium payment within 31 days of the date your county coverage ends (see Resource Directory booklet). If you die during the 31 days, your beneficiary or estate will receive the full amount of your life insurance coverage in force before it ended. This payment is made under the group policy, whether or not you actually applied to continue coverage. If you applied, any fees or premiums you paid are refunded.

Converting to Individual Whole Life Insurance

You, your spouse/domestic partner and child may apply to convert group term life insurance to an individual whole life insurance policy if you (the county employee):

- Leave county employment for any reason
- Elect to continue group term life insurance when you leave county employment but discontinue it or lose eligibility for it later.

To convert group term life insurance to an individual whole life insurance policy, you or the covered family member must apply to Aetna within 31 days of the date your group term life insurance coverage ends (see Resource Directory booklet). If you die during the 31-day conversion period, your beneficiary or estate receives the full amount of your life insurance coverage. This payment is made whether or not you actually applied to continue coverage. If you already applied, any fees or premiums you paid are refunded.

Payment of Benefits

The benefits offered by this plan are insured by Aetna, meaning this is not a self-funded plan. Aetna is financially responsible for claim payments and other costs.

Booklet 7

CIGNA Accidental Death and Dismemberment Insurance

Although these benefit descriptions include certain key features and brief summaries of King County regular employee and part-time Local 587 benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

Table of Contents: CIGNA AD&D Insurance

Overview

► Highlights of CIGNA Accidental Death and Dismemberment Insurance

AD&D insurance is only available to regular employees and part-time Local 587 employees in Plan 2 or Plan 3; it is not available to employees in part-time Local 587 employee Plan 1. Here are a few highlights of the plan:

- Basic and enhanced AD&D insurance is provided by CIGNA
- You automatically receive basic AD&D insurance paid by the county
- You may purchase additional ("enhanced") AD&D insurance for yourself and eligible family members
- You must enroll in enhanced AD&D insurance to enroll your family members
- If you or a covered family member dies in a covered accident, AD&D benefits are paid in addition to any life insurance benefits
- Additional benefits, depending on the how accidental death or injury occurs, are available through the plan
- If you travel 100 or more miles from home, predeparture, travel and health emergency help is available
- You have options to continue AD&D insurance when you leave county employment.

► Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:

- Who's eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and the options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

► Basic AD&D

The county pays the entire cost of basic AD&D insurance for regular employees and part-time Local 587 employees in Plan 2 or 3. Basic AD&D is not available to part-time Local 587 employees in Plan 1.

► Enhanced AD&D

If you are eligible and elect enhanced AD&D insurance (enhanced AD&D is not available under part-time Local 587 Plan 1), you pay a monthly premium through payroll deduction. Your cost depends on the amount of insurance you elect and who is covered. You may cover a spouse/domestic partner at 50% or 100% of your enhanced amount and children at 10% of your enhanced amount. If you cover children, the cost is the same no matter how many children you cover.

See the latest new hire guides and open enrollment materials for information about the monthly cost of coverage.

Amount of Coverage

Basic AD&D for Regular Employees. You automatically receive county-paid basic AD&D insurance. If you die within one year of a covered accident and your death is due to the accident, the beneficiaries you designate receive a lump sum equal to your base annual salary (rounded to the next higher $1,000, to a maximum of $200,000). For specified dismemberment, paralysis and other losses, you receive a portion of or the full amount, depending on the type of loss (see "When Benefits Are Payable" in this booklet).

Your base annual salary is your base pay excluding overtime, bonuses, premium or any other special pay. Since your basic AD&D benefit is equal to your base annual salary, it automatically increases as your salary increases. Adjustments to the basic AD&D benefit due to a salary change automatically occur the first of the month following the salary change, unless you are on an approved unpaid leave. In that case, the adjustment occurs on the first of the month following the date you return to active work.

Basic AD&D for Part-Time Local 587 Employees in Plan 2 or Plan 3. You automatically receive county-paid basic AD&D insurance. If you die within one year of a covered accident and your death is due to the accident, the beneficiaries you designate receive $25,000. For specified dismemberment, paralysis and other losses, you receive a portion of or the full amount, depending on the type of loss (see "When Benefits Are Payable" in this booklet).

Basic AD&D is not available to part-time Local 587 employees in Plan 1.

Enhanced AD&D for Regular and Part-Time Local 587 Employees in Plan 2 or Plan 3. You may purchase enhanced AD&D insurance in $50,000 increments, from $50,000 to a maximum of $500,000. If you die within one year of a covered accident and your death is due to the accident, the beneficiaries you designate receive the amount you elect in addition to your county-paid basic AD&D insurance benefit. For specified dismemberment, paralysis and other losses, you receive a portion of or the full amount, depending on the type of loss (see "When Benefits Are Payable" in this booklet).

After it's been in effect for 12 consecutive months, enhanced coverage for both you and your covered family members increases 1% every January 1 until it's been increased by a maximum of 10%. Each year's increase is calculated on the prior year's coverage amount. There is no additional cost for this "escalated" coverage.

Enhanced AD&D is not available to part-time Local 587 employees in Plan 1.

Enhanced AD&D for Your Family. If you elect enhanced AD&D insurance for yourself, you may purchase enhanced AD&D for family members:

- Spouse or domestic partner at 50% or 100% of your enhanced amount to a maximum of $500,000
- Child(ren) at 10% of your enhanced amount to a maximum of $50,000 (if you cover one child, all your eligible children are covered).

If you and your spouse/domestic partner both work for King County, neither of you may be insured as both an employee and as a dependent at the same time. You may not cover each other, and only one of you may cover your eligible children under this plan. However, you may add your spouse/domestic partner and children for coverage if they lose their county coverage (see "Changes You May Make When a Qualifying Change Occurs" in the Important Facts booklet).

Evidence of Insurability

No evidence of insurability (EOI) is required to enroll for AD&D insurance.

Reduction in the Amount of Coverage

Coverage ends at age 80 for your spouse/domestic partner and at age 23 for dependent children. For you and a covered spouse/domestic partner, AD&D benefit amounts are reduced:

- By 30% (to 70% of the benefit amount) for ages 70-74
- By 55% (to 45% of the benefit amount) for ages 75-79
- By 70% (to 30% of the benefit amount) for ages 80-84 (employee only)
- By 85% (to 15% of the benefit amount) for ages 85 and over (employee only).

Beneficiaries

You need to designate one or more beneficiaries – individuals who receive your benefit in the event of your death. A Beneficiary Designation form is provided when you first enroll and is available on the Web and from Benefits and Retirement Operations anytime you need to change beneficiaries (see Resource Directory booklet).

You may name anyone you wish as your primary or contingent beneficiaries (contingent beneficiaries receive benefits if all primary beneficiaries are deceased at the time of your death). If you don't designate beneficiaries as primary or contingent on your Beneficiary Designation, all beneficiaries you list are considered primary.

You may designate more than one primary and one contingent beneficiary. When you do, you must assign the percentage of your benefit each beneficiary receives on your Beneficiary Designation. Percentages for all primary beneficiaries must total 100% and percentages for all contingent beneficiaries must total 100%. If you don't assign percentages, beneficiaries receive equal shares.

If you're married and you do not choose to list your spouse as your only primary beneficiary, your spouse must sign the spouse waiver section of the Beneficiary Designation.

You may change your beneficiary at any time by completing a new Beneficiary Designation and sending it to Benefits and Retirement Operations. Benefits are paid according to the most recently signed form on file. If you don't name a beneficiary, benefits are paid to your spouse, your children, your parents or your siblings, in that order. If none of them survives you, benefits are paid to your estate.

If you elect enhanced AD&D coverage for your family members and a covered family member dies, you are the beneficiary. Benefits for dismemberment, paralysis and other losses to you or your covered family members are paid to you.

When Benefits Are Payable

Benefits are payable for death, specified dismemberment, paralysis and other losses that occur within 365 days of the covered accident that caused the covered loss. To receive benefits, you or your covered family member must be covered by the plan on the date of the accident.

Loss of Life. If you or a covered family member dies in a covered accident, the full AD&D benefit amount is payable (subject to the reductions for age as described in "Reductions in the Amount of Coverage").

Accidental Dismemberment and Paralysis. AD&D insurance protects you against losses due to accidents. Depending on the type of loss or injury, this plan pays up to 100% of the full AD&D benefit amount for you or your spouse/domestic partner (subject to the reductions for age as described in "Reductions in the Amount of Coverage") and up to 200% of the full benefit amount for your covered children. To help survivors of severe accidents adjust to new living circumstances, certain benefits are payable for paralysis, dismemberment and loss of eyesight, speech or hearing according to the following table.

Type of Loss	Benefit Payable for You or Your Spouse/ Domestic Partner	Benefit Payable for Your Children
• Life • Both hands or both feet, or sight in both eyes or any combination • Speech and hearing in both ears • Quadriplegia: total paralysis of both arms and legs	Full benefit amount (see "Amount of Coverage")	100% of the full benefit amount for life; 200% of the full benefit amount for other losses listed
• Paraplegia: total paralysis of both legs	75% of the full benefit amount	150% of the full benefit amount
• 1 hand or 1 foot or sight in 1 eye	50% of the full benefit amount	100% of the full benefit amount

Type of Loss	Benefit Payable for You or Your Spouse/ Domestic Partner	Benefit Payable for Your Children
• Speech • Hearing in both ears • Hemiplegia: total paralysis of an arm and leg on 1 side of the body		
• Thumb and index finger on the same hand	25% of the full benefit amount	50% of the full benefit amount

Only one amount (the largest you are entitled to receive) is paid for all losses resulting from a single accident.

A loss is defined as:
- Loss of hearing – irrecoverable loss of hearing that cannot be corrected by any hearing aid or device
- Loss of hand or foot – complete severance of a limb at or above the wrist or ankle joint
- Loss of sight – total and irrecoverable loss of sight
- Loss of speech – complete inability to communicate audibly in any degree
- Loss of thumb and index finger – complete severance of the thumb and index finger through or above the joint closest to the wrist
- Paralysis of a limb – complete and irreversible loss of use, without severance of a limb (this loss must be determined by a physician to be complete and not reversible)
- Severance – complete separation and dismemberment of the limb from the body.

Felonious Assault Benefit for Employees

If you are injured or killed as a result of felonious assault while on county property or on county business, this plan pays up to an additional 25% of your basic AD&D benefit (up to $50,000). This additional benefit is available if your injury or death is the result of actual or attempted robbery or holdup (or kidnapping associated with a holdup). Felonious assaults inflicted by county employees or members of your family or household are not covered.

Additional Benefits for Employees and Covered Family Members

► Child Care Benefit

If you or your covered spouse/domestic partner dies as a result of a covered accident and you have a surviving child under age 13 in a licensed child care center (or if your child is enrolled within one year of the parent's death), a child care benefit is payable at the time of death or within one year. This is an annual sum for each covered child of up to 3% of your enhanced AD&D benefit amount to a maximum of $3,000 a year until the child enters first grade or for five straight years, whichever occurs first.

If, at the time of the accident, coverage for a dependent child is in force, but there is no dependent child who qualifies, the designated beneficiary receives an additional benefit of $1,500.

The payment is made to the child's surviving custodial parent or legal guardian. Each payment is made at the end of a 12-month period with documented child care center expenses.

► Coma Benefit

This plan pays an additional benefit if you or a covered family member enters a coma as a result of a covered accident within 31 days of the accident. After 31 days, the plan makes monthly payments of 1% of the full AD&D benefit amount – up to 11 monthly payments. If you or your family member recovers, the payments will stop.

If you or your family member dies as a result of a covered accident while receiving the monthly coma benefit, the plan pays the full benefit amount (the amount already paid is not subtracted from the death benefit amount).

If the coma continues after the 11 monthly payments, the covered person is entitled to a lump sum equal to the full benefit amount, minus any amount the plan paid or owes under the dismemberment, loss of sight, speech or hearing and paralysis benefit. No further benefit will be paid from this plan, and coverage will end.

No coma benefit will be paid for any loss excluded from the plan. In addition, the coma benefit is not payable for a loss resulting from sickness, disease, bodily infirmity, medical or surgical treatment or a bacterial infection (unless it results from an accidental external injury or food poisoning) or viral infection.

► Education Benefit

If you elect enhanced AD&D coverage for your child and you or your covered spouse/domestic partner dies in a covered accident, the plan pays an extra benefit for each covered child enrolled in an accredited school of higher learning (or in the 12th grade and enrolled in an accredited school of higher learning within one year of the accident). To help pay expenses, your benefit amount increases by 5% (up to $5,000) for each qualifying child. This benefit is payable each year for four consecutive years as long as the child continues education.

If you don't have a qualifying child, your beneficiary receives an additional $1,000.

► Rehabilitation Benefit

If you or a covered family member experiences a covered loss or injury, this plan pays an additional benefit for covered rehabilitative expenses due to the loss or injury if they're incurred within two years of the accident. This benefit maximum is $10,000 in rehabilitative expenses for all losses or injuries caused by the same accident. No rehabilitation benefit will be paid for any loss not covered by the plan. In addition, benefits will not be payable if a covered person is entitled to benefits under any Workers' Compensation Act or similar law.

► Seatbelt/Airbag Benefit

This plan pays an additional benefit of 10% of the full AD&D benefit amount, up to $25,000, if a seatbelt fails to protect you or a covered family member. The accident causing death must occur while the covered person is operating, or riding as a passenger in, an automobile and wearing a properly fastened, original, factory-installed seatbelt. A child restraint as defined by state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for children of like age and weight at the time of the accident, also qualifies as a seatbelt.

The plan pays an additional 5% of the full AD&D benefit amount, up to $12,500, if a seatbelt benefit is payable and the covered person is positioned in a seat protected by a properly functioning, original, factory-installed supplemental restraint system that inflates on impact (often called an airbag).

Verification of actual seatbelt use at the time of accident and airbag inflation at impact must be part of an official accident report or be certified, in writing, by the investigating officer. If that certification is not available and it's unclear whether the covered person was wearing a properly fastened seatbelt, the designated beneficiary receives a fixed benefit of $1,000.

► Secure Travel

If you or a covered family member travels 100 or more miles from home, predeparture, travel and health emergency help is available through Worldwide Assistance Services Inc. (see the Resource Directory booklet).

Predeparture Services. These services include information on immunization requirements, visa and passport regulations, foreign exchange rates, embassy/consular referral, travel/tourist advisories, climate and cultural issues.

Travel Assistance. When you are traveling, Worldwide Assistance will:
- Help you locate and replace luggage, documents and any other lost or stolen possessions
- Arrange aid from local attorneys, embassies and consulates if you need legal assistance, and provide up to $5,000 in bail bond, where permitted by law (you must guarantee reimbursement)
- Provide phone translation or local interpreters for all major languages
- Give you a cash advance up to $250 (you must guarantee reimbursement)
- Change or make new airline, hotel or car rental reservations in the event of an emergency
- Relay urgent messages to and from friends, relatives and business associates through the Emergency Message Center.

Health Emergency Assistance. If an unforeseen health emergency arises while you're traveling, Worldwide Assistance will:
- Provide referrals to local physicians, dentists and medical treatment facilities
- Assist you with refilling a prescription that has been lost, stolen or depleted
- Arrange for payment of up to $5,000 of your reimbursable medical expenses (as determined by your medical plan)
- Pay for your transportation to the nearest medical facility where a medical condition can be properly treated if medically necessary (determined by a Worldwide Assistance-designated physician)
- Arrange and pay for the safe return of any dependent children under age 16 if you are hospitalized and for a traveling companion's return in the event of delays due to your medical emergency
- Arrange and pay for a visit by a family member or friend if you are traveling alone and hospitalized for at least 10 days
- Arrange all necessary government authorizations and pay for the return of your remains to your place of residence for burial or cremation in the event you die.

► Special Care Benefit for Children

If your covered child has a severe covered accidental injury, you receive double the AD&D benefit amount, up to $50,000. If your child has two covered losses, only the larger amount payable will be doubled. If, in addition to a covered loss, your child dies within 90 days of the covered accident, only the death benefit is payable.

This benefit can help you cope with the ongoing financial obligations for a child who requires continued medical attention, rehabilitation services and a specialized education.

► Violent Crime Benefit

This plan pays up to an additional 25% of your enhanced AD&D benefit (to $100,000) if you or a covered family member suffers a covered loss due to a violent crime. The plan also pays an additional benefit for hospital confinement as a result of a violent crime – $100 a day up to a maximum of 10 days (hospital confinement must begin within 30 days of the crime).

This additional benefit applies to these crimes:
- Actual or attempted robbery or holdup
- Actual or attempted kidnapping
- Any other type of assault classified as a felony based on governing statute or common law in the state where it occurred.

Violent crimes committed by county employees or members of your family or household are not covered.

A copy of a police report containing proof the loss was a direct result of a covered crime must be provided before any AD&D benefit is paid.

Exclusions and Limitations

No AD&D benefits are paid for loss resulting from:

- Intentionally self-inflicted injuries, or any attempted self-inflicted injuries, while sane or insane
- Declared or undeclared war or act of war
- Accident occurring while the covered person is serving on full-time active duty for more than 30 days in any Armed Forces (send CIGNA proof of service, and any premium paid for this time will be refunded); Reserve or National Guard active duty for training is not excluded
- Travel or flight (including getting in or out, on or off) in any aircraft or device that can fly above the earth's surface, if:
  - The aircraft or device is being used for any of these purposes:
    - For test or experiment
    - By or for any military authority (aircraft flown by the US Military Airlift Command or similar service of another country are not excluded)
    - For travel beyond the earth's atmosphere, or
  - The covered person is doing either of the following:
    - Piloting, serving as a crew member or taking flying lessons (exclusion does not apply if riding as a passenger)
    - Hang-gliding
    - Parachuting, except a parachute jump for self-preservation
- The covered person committing a felony
- Sickness, disease, bodily or mental infirmity, medical or surgical treatment or bacterial or viral infection, regardless of how contracted (except bacterial infection that is the natural and foreseeable result of an accidental external cut or wound, or accidental food poisoning).

Filing a Claim

For a death, specified dismemberment or paralysis claim, you or your beneficiary should contact Benefits and Retirement Operations. Benefits and Retirement Operations staff will help file the claim with CIGNA and provide referrals to counseling and other resources as requested. The claim should be filed within 90 days of the loss or death.

CIGNA requires proof of loss (for example, a certified copy of death certificate or accident report) within 90 days of the loss, or as soon as reasonably possible, before benefits are payable. For a death claim, CIGNA may, at its own expense, have an autopsy performed to determine a death benefit payment, unless prohibited by law. While a dismemberment or paralysis claim is pending, CIGNA may have the covered person examined by a health or vocational professional of their own choice and expense, as often as reasonably necessary.

CIGNA processes the claim within 90 days of receipt. If CIGNA needs more time, you or your beneficiary are notified in writing, before the initial 90 days end, of the need for an extension of up to 90 days.

If the claim is denied, you or your beneficiary are notified in writing of reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that the plan reviewed in making the determination.

Appealing Denied Claims

► Claims Denied for Reasons Other Than Eligibility

When a claim is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim is denied for eligibility reasons, follow the steps described in the next section, "Claims Denied Due to Eligibility."

If you or your beneficiary disagrees with a claim denial, you, your beneficiary or representative (referred to as "you" in the rest of this section) may try to resolve any misunderstanding by calling CIGNA and providing more information. If you'd rather communicate in writing or the issue isn't resolved with a call, you may file a written appeal. You have 60 days after receiving a claim denial notice to file the written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

CIGNA will review the written appeal and notify you of its decision within 60 days after receiving the appeal. If CIGNA requires additional time, you will be notified in writing that an additional period of up to 60 days is necessary.

CIGNA will give you a written decision and explain the specific plan provisions behind the denial (if applicable).

CIGNA has sole discretionary authority to determine benefit payment under the AD&D insurance plan; its decision is final and binding. In reviewing your claim, CIGNA applies the plan terms and use its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and CIGNA determines you're entitled to the benefits.

If the appeal is denied, you may pursue legal remedies, but you must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within three years after the time written proof of loss is required to be furnished. If you do not file a claim or appeal within the specified period, you forfeit the right to further appeal.

► Claims Denied Due to Eligibility

If you have eligibility questions or believe you've had a claim denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you, your beneficiary or representative (referred to as "you" in the rest of this section) may file a written appeal. You have 60 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you in writing of the eligibility determination within 60 days. If additional time is required, you will be notified in writing that an additional period of up to 60 days is necessary.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an appeal addendum within 60 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address as for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you were denied plan participation, or you forfeit your right to legal action.

Converting Your Coverage

If this group AD&D coverage ends for any reason except non-payment of premium, you and covered family members may convert to an individual policy. No medical certification is needed, but you and your family members must be under age 70.

To convert coverage, you or your family member must apply and pay your first premium within 31 days of the date your county coverage ends.

For information about converting your coverage, contact CIGNA (see the Resource Directory booklet).

Payment of Benefits

The benefits offered by this plan are underwritten by Life Insurance Company of North America, a division of CIGNA Corporation, meaning this is not a self-funded plan. Life Insurance Company of North America is responsible for claim payments and other costs.